THE ALAMEDA COUNTY PLAN FOR MENTAL HEALTH SERVICES FOR FISCAL YEAR 1979-80

PROPOSED AND SUBMITTED TO
THE STATE OF CALIFORNIA
DEPARTMENT OF HEALTH

By

THE ALAMEDA COUNTY BOARD OF SUPERVISORS

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INTRODUCTION

In the 1978-79 Short-Doyle Plan, certain themes and directions for Mental Health Service were established. It seems appropriate as an introduction to the 1979-80 Plan to reflect on how the Agency did or did not pursue last year's directions. The 1978-79 themes/directions included:

1. development of models for minority services
2. consumer input in all phases of mental health
3. emphasis on children's service planning
4. interagency linkages
5. evaluation consistent with 1979-80 planning cycle

Current status of five themes:

1. Development of strategy for minority programming: The Mental Health Planning Office intends to conduct a workshop on the subject of model building for minority program design alternatives during the summer of 1979.

2. Consumer input: The Mental Health Service has made progress in including consumers in the 1979-80 planning process. A consumer feedback survey is in process of development and will be distributed during the summer of 1979.

3. Planning for children's service: The elimination of the Deputy Director for Children's Services position during Proposition 13 budget reductions hampered efforts at planning new or more coordinated children's services.

   All children's services management staff have assumed some responsibility for planning new services. A proposal for an adolescent day treatment program under AB 3052 is one result of many individual efforts. There is much more work to be done in succeeding years.

4. Interagency coordination: Despite turmoil resulting from Proposition 13 reductions in staff and program, an Interagency Committee for Children's Services was established. The Committee is composed of representatives from Mental Health, Probation and Social Services. Its initial efforts involve work around facilitating placement coordination, facility planning and exploration of funding alternatives for programs. It is a very positive step for improving children's services in Alameda County.

   The Interagency Committee for Criminal Justice Mental Health continues to function as an advocacy, planning, and problem-solving group.

   The need for interagency cooperation in service delivery to the adult continuing care client resulted in a joint effort by Social Services, the Public Guardian and Mental Health for a substitute payee unit.

It is hoped that 1979-80 will result in development of inter-agency efforts for the elderly, continuing care client, and the disabled.

5. Evaluation: The Evaluation Unit of the Mental Health Department was severely impacted by Proposition 13 reductions. Positions were eliminated (one was subsequently restored) and staff resignations resulted in a 100% vacancy factor for a period of time.

   The Evaluation Unit has been reorganized as part of the Mental Health Quality Assurance Office and has all new staff. The future of the evaluation program is most exciting.

   As for the 1979-80 planning process, the evaluation effort was severely limited by the fact that there was no Evaluation Unit for the design phase of the Plan.

In summary, it may be said that, despite program chaos post Proposition 13, some progress was made in 1978-79 toward achieving the Short-Doyle Plan goals for the year.

1979-80 Plan

The 1979-80 Plan suggests numerous administrative and program directions for mental health services in Alameda County Mental Health Service. It will be necessary for the Mental Health staff to evaluate the suggestions in the Plan as to feasibility given current staff and budget constraints. The Plan will be useful in helping the administration in making management decisions. A response to the recommendation and an action plan will be developed by October, 1979.

The process of the last three years of mental health planning in California was a product of close state-county cooperation in designing guidelines that would facilitate development of sound mental health services.

It is hoped that the designing of guidelines for future planning will involve the same close cooperation between local-state agencies and advisory groups.

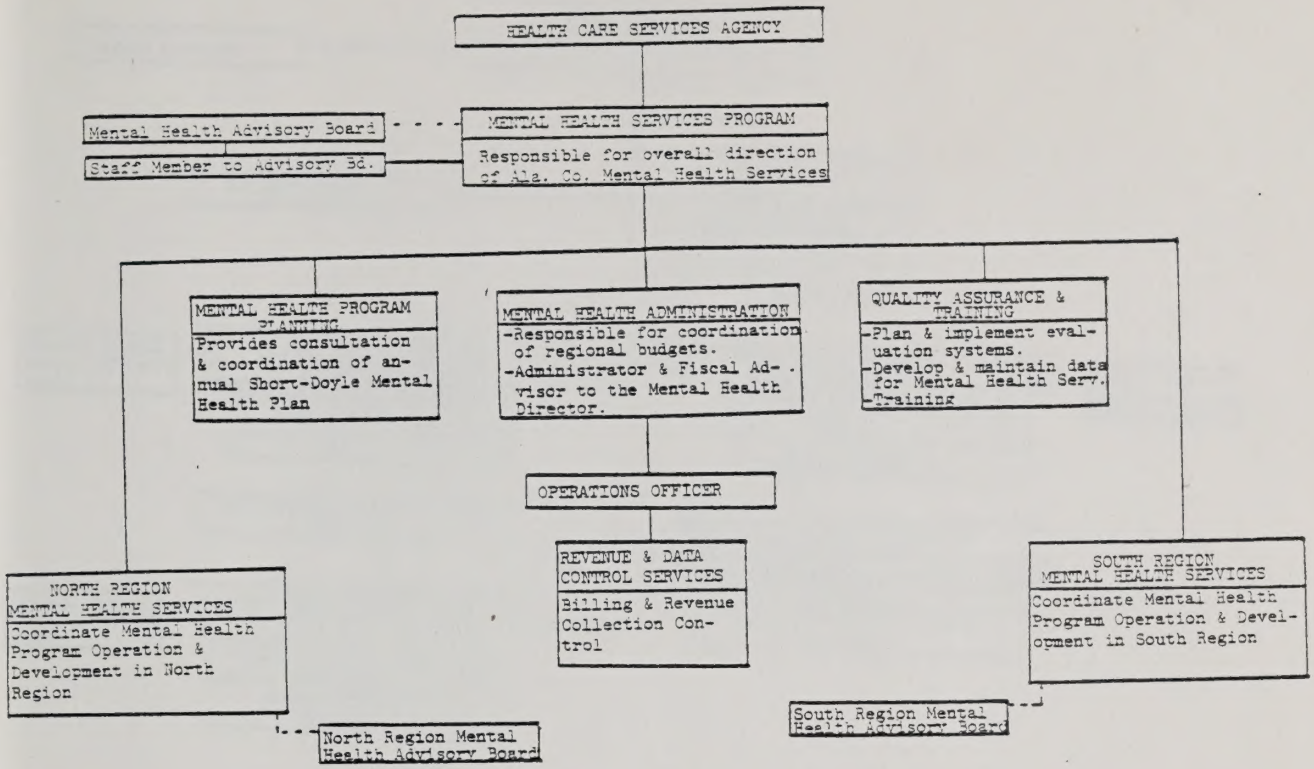
Susan Mandel, Ph.D.
Local Mental Health Director

SECTION I

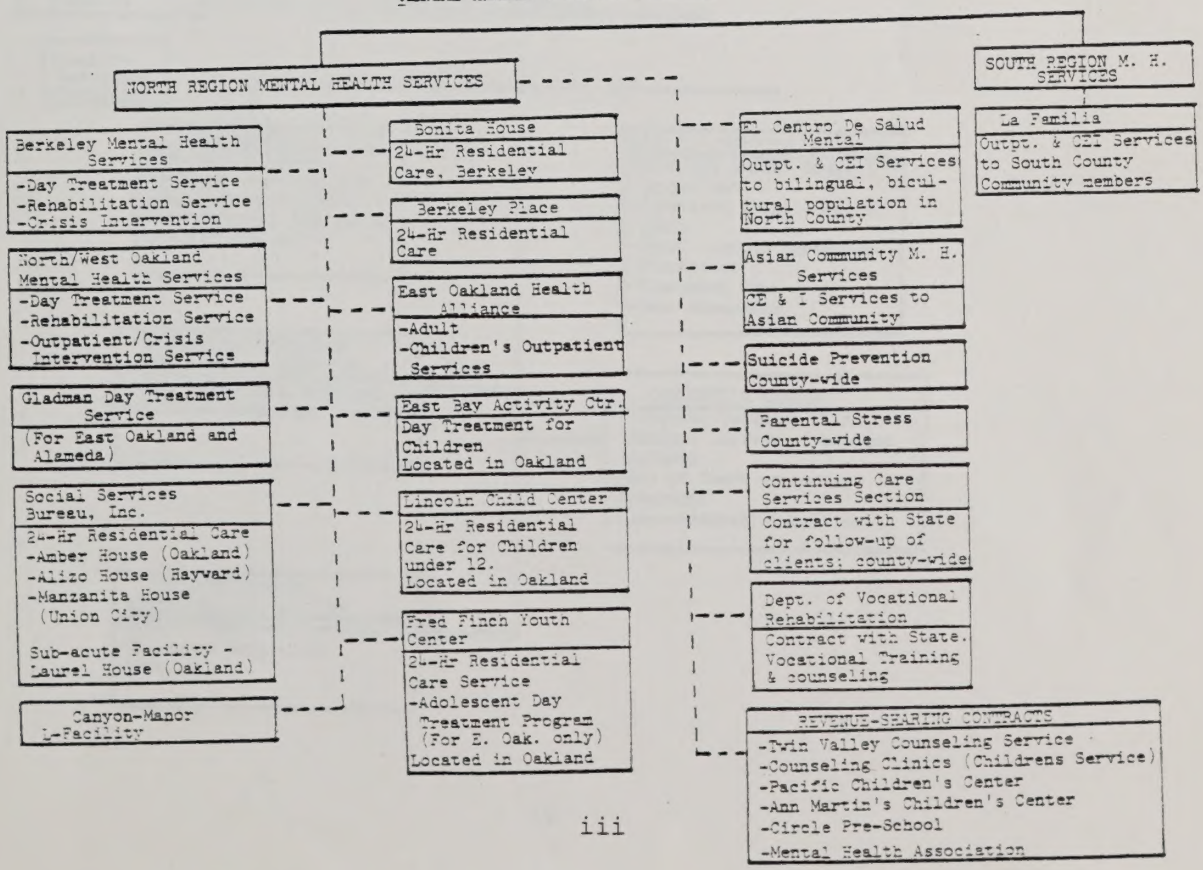
ORGANIZATIONAL CHARTS

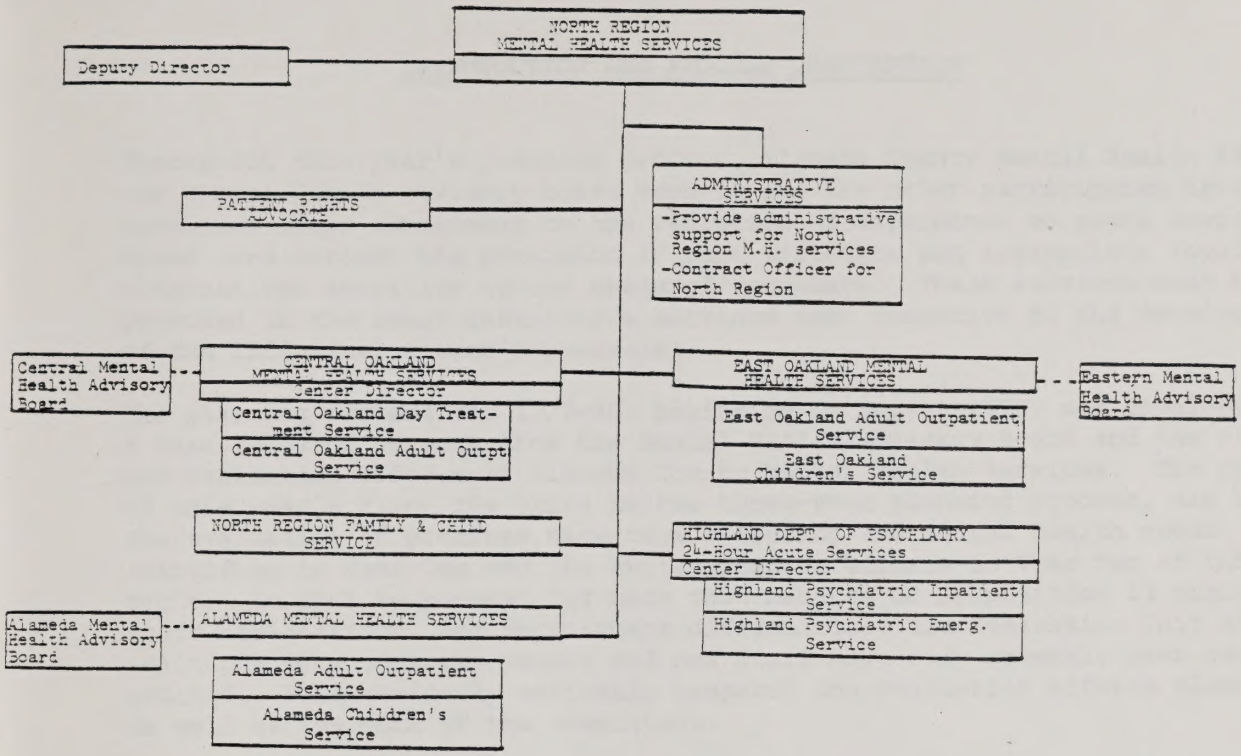
ORGANIZATIONAL CHARTS

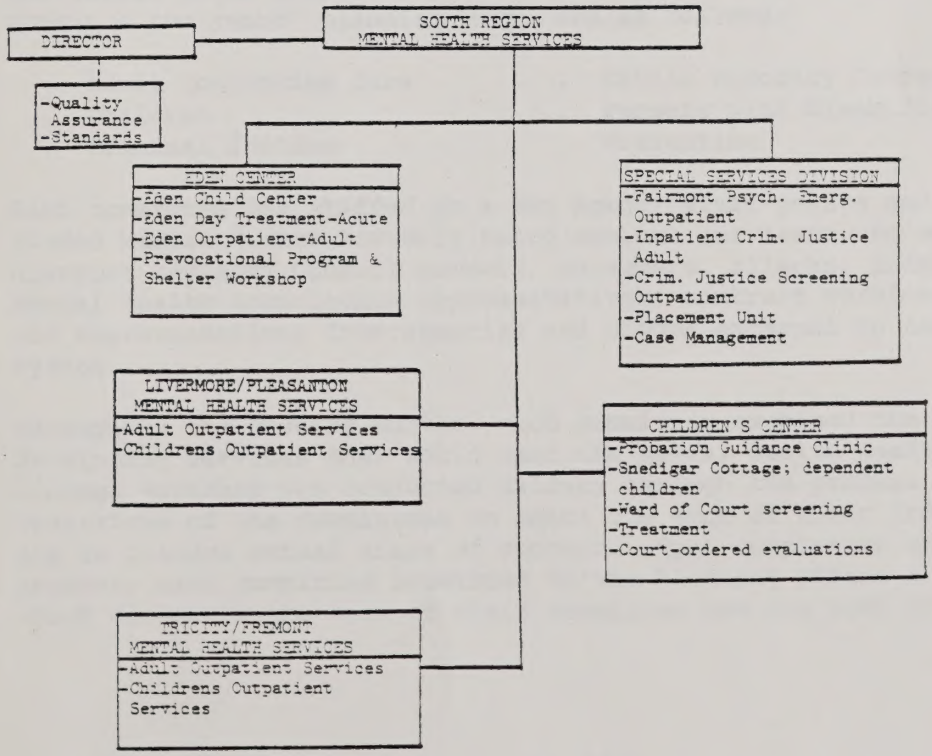
ALAMEDA COUNTY



MENTAL HEALTH CONTRACT PROGRAMS




NORTH REGION
MENTAL HEALTH SERVICES
Deputy Director
PATIENT RIGHTS ADVOCATE
ADMINISTRATIVE SERVICES
-Provide administrative support for North Region M.H. services
-Contract Officer for North Region
Central Mental Health Advisory Board
CENTRAL OAKLAND MENTAL HEALTH SERVICES
Center Director
Central Oakland Day Treatment Service
Central Oakland Adult Outpt Service
EAST OAKLAND MENTAL HEALTH SERVICES
Eastern Mental Health Advisory Board
East Oakland Adult Outpatient Service
East Oakland Children's Service
NORTH REGION FAMILY & CHILD SERVICE
HIGHLAND DEPT. OF PSYCHIATRY
24-Hour Acute Services
Center Director
Highland Psychiatric Inpatient Service
Highland Psychiatric Emerg. Service
Alameda Mental Health Advisory Board
ALAMEDA MENTAL HEALTH SERVICES
Alameda Adult Outpatient Service
Alameda Children's Service


SOUTH REGION
MENTAL HEALTH SERVICES
DIRECTOR
-Quality Assurance
-Standards
EDEN CENTER
-Eden Child Center
-Eden Day Treatment-Acute
-Eden Outpatient-Adult
-Prevocational Program & Shelter Workshop
SPECIAL SERVICES DIVISION
-Fairmont Psych. Emerg. Outpatient
-Inpatient Crim. Justice Adult
-Crim. Justice Screening Outpatient
-Placement Unit
-Case Management
LIVERMORE/PLEASANTON MENTAL HEALTH SERVICES
-Adult Outpatient Services
-Childrens Outpatient Services
CHILDREN'S CENTER
-Probation Guidance Clinic
-Snedigar Cottage; dependent children
-Ward of Court screening
-Treatment
-Court-ordered evaluations
TRICITY/FREMONT MENTAL HEALTH SERVICES
-Adult Outpatient Services
-Childrens Outpatient Services

INTRODUCTION AND PROCESS DESCRIPTION

Throughout this year's planning process, Alameda County Mental Health Services, the Mental Health Advisory Board members and the other participants have continued their commitment to the reduction of dependence on acute hospital-based care through the provision of cost-efficient and appropriate local alternatives sensitive to the needs of consumers. These services must be provided in the least restrictive settings most conducive to the development of the individual client's potential.

The planning process for 1979-80, beginning in August 1978, was developed by a task force of persons from the Mental Health Advisory Board and the Planning and Evaluation Offices of Alameda County Mental Health Services. The focus of this year's Plan, the third in the three-year planning process, has been the evaluation of progress made toward meeting the mental health needs identified in Year One and the implementation efforts in Year Two of this cycle. It must be pointed out here that because of Proposition 13 cutbacks, staff resignations, and recruitment difficulties, the Evaluation Unit staff positions were entirely vacant and new staff have only recently been recruited. This obviously seriously hampered the evaluation efforts planned, as well as the work of the committees.

Six planning committees addressed the following questions:

- What have we done?
- How much progress has been made?
- What still needs to be done?

The issues to be examined by these committees, based on the results of the previous two years' planning work, are as follows:

- Adult Continuing Care
- Children
- Criminal Justice
- Ethnic Minority Concerns
- Persons with Disabilities
- Prevention

Each committee was staffed by a key Agency staff person and membership included Mental Health Advisory Board members (at least one on each committee), District Advisory Council members, consumers, clients, interested citizens, Mental Health Association representatives, contract services representatives, and representatives from agencies and groups external to the mental health system.

Throughout the ensuing months, each committee examined the progress made in developing services that would meet the mental health needs of clients. A Linkage Workshop was conducted halfway through the process to allow representatives of the committees to share the work of their individual groups and to discuss mutual areas of concern. Upon completion of the planning process, each committee submitted to the Planning Office a written report which documents the work of their committee and the body of this Plan.

As a final step in the planning process, an Ad Hoc Plan group, comprised of three Mental Health Advisory Board members, three Agency persons, and staffed by the Planning Office, reviewed all of the reports, making some additional comments on the issues, identifying common themes or issues that cut across all the committee reports and discussing overall directions for future planning efforts.

The reports that follow are a result of the planning process described and have been edited by the Planning Office for context, consistency, and clarity.

SECTION II

EVALUATION PHASE

CHILDREN'S SERVICES

I. INTRODUCTION AND BACKGROUND

The goal of the Alameda County Children's Mental Health Services is the provision of a comprehensive spectrum of child and adolescent services (direct and indirect), that are geographically, culturally, and linguistically sensitive and accessible and that emphasize family involvement. Within this existing range of services, both County-operated and contract, the priority patients to be served are:

A. Those children with a history of psychiatric hospitalization at either state or local, public, or private facilities.

B. Those children never hospitalized, but at risk of requiring such care if appropriate services are not provided.

Throughout the three-year planning cycle, the emphasis has been on the need for bilingual/bicultural day treatment and residential facilities as identified in the needs assessment. Additional issues regarding interagency cooperation, placement, preventive services, and the special needs of minority children have been examined. Some of the more pressing needs of children and their families are presented in this report. The committee's work is, of course, not exhaustive, and there are many ongoing unmet needs not addressed. The summary of projected new and expanded programs contained in this Plan (see Table of Contents) describes some specific services necessary to a comprehensive, sensitive range of services to children and families. In addition, Mental Health Administration is currently analyzing AB 1339 and its potential impact on Alameda County Mental Health services for children.

In this year's planning process, the Children's Advocacy Committee (a joint effort of the Alameda County Mental Health Advisory Board and the Mental Health Association) has assessed the progress made in improving the mental health services available for children. The membership of this committee includes representation from:

- Providers of services, County-operated and contract
- Mental Health Association
- Mental Health Advisory Board
- Public interest
- Private practitioners
- Mental Health Services staff
- Other public and private agencies, i.e. schools, Probation, etc.

II. TASK AND APPROACH

Analysis early in this year's planning process revealed that no progress has been made toward developing the specific services identified in the

first year (needs assessment) of the three-year planning cycle. Day treatment and residential facilities with bilingual/bicultural capabilities were among the highest prioritized needs. Program plans for these services have consistently been submitted to the State Department of Mental Health for funding although as yet, resources have not been made available for implementation.

Despite this disturbing lack of progress, the committee focused on three major tasks for this year's planning effort.

A. Documentation of the impact of Proposition 13 on children's services.

B. A preliminary analysis of the Juvenile Justice Mental Health system, assessing the problems and possible solutions and directions.

C. In an effort to begin evaluating the acceptability and accessibility of services offered to children and their families from the clients' perspectives, an evaluation instrument was developed and tested on a limited basis. This survey provides some useful feedback from the parents of children being seen at five County-operated outpatient facilities.

The following section presents the results of the committee's work.

III. RESULTS

A. IMPACT OF PROPOSITION 13 ON CHILDREN'S SERVICES

The passage of Proposition 13 resulted in serious damage to children's mental health programs in Alameda County. Some of the effects have diminished as programs have returned to functioning levels while other effects are cumulative and are continuing with long-term ramifications.

Budget

The budget for County-operated and contract services for children was reduced through position cutbacks in several County-operated children's services, a 10% reduction of the largest Short-Doyle contracts, and through a 10% cut of all Revenue Sharing contracts including five agencies serving children.

Administration

The position of the Deputy Director for Children's Services was eliminated. The Deputy Director was responsible for many of the crucial administrative liaisons to the State Department of Mental Health, the State hospital, other County departments, community

groups, and the private sector, as well as for planning and evaluation tasks. With shortages of staff at lower administrative levels, many critical functions have been reassigned with less critical functions not being addressed.

Direct Services

The staffs of Probation Guidance Clinic and Dependent Children's Clinic were initally reduced by half, and were restored at approximately 75% of the FY 1977-78 levels in the final 1978-79 budget. Some staff of other County-operated outpatient clinics were "bumped" out of jobs by Proposition 13 lay-offs, a process which significantly reversed the services' efforts at affirmative action hiring. Staff who replaced laid-off employees were often not experienced in treatment of children, adolescents, or families. Several vacancies were subsequently created by resignations of employees who survived cuts and the bumping process, but chose to leave the system. Increasing administrative demands on management staff in Children's Services caused some of them to reduce or terminate their own small treatment caseloads, further reducing clinic capabilities to provide direct services. During July-December of 1978, County-operated Children's services provided direct services at 59% of the levels provided during the same period in 1977. Many clinics developed waiting lists of one month or longer following an initial screening even with graduate students and residents providing services. The general impression has been that families with more severe disturbances were requesting services yet could not be seen immediately.

The majority of vacancies in County services were filled by February 1979, and waiting lists have been eliminated or reduced. Some clinics have reported lower than usual referral rates which may be a result of the clinics' reduced capacity to serve families earlier in the year, or a result of the impact of Proposition 13 on other referring agencies (schools, Welfare, Health, Probation, etc.).

State Hospital Admissions of Children and Adolescents

The critical need for residential and day treatment services for children and adolescents in Alameda County was again illustrated by an alarming increase in the censuses at Napa and Stockton State Hospitals. The population of patients under 18 had never exceeded 30; between July - December 1979, the population rose to 45 and has stabilized at 38-40. All admissions during this period were adolescents between 14-18 years and the majority were court wards (on probation or court dependents) with histories of serious acting-out behavior and at least one out-of-home placement or hospitalization prior to referral to the State hospital. The closure of the Diagnostic Unit under the Probation Department and the attempted closure of Snedigar Cottage for court dependents post-Proposition 13 combined with the reduction at related mental health units and contributed to the increased admission rates. The disruption of the network of services

which help to maintain many at-risk youngsters in the community (summer school, recreation activities, probation, or dependency supervision, etc.) probably also increased the admission rates. Limited community resources for patients upon discharge has added to the length of stay. The projected annual costs of 49 patients in the State hospital youth programs is $1.7 million, an increase of approximately $410,000 in one year.

Consultation, Education, and Information Services

Consultation, education, and information services were a prioritized need at the beginning of the three-year planning cycle. As documented in the Alameda County Mental Health Services workload standards for children's outpatient services, County-operated children's programs are mandated to provide a significant proportion of these services to the community. With staff reductions and vacant positions, these prevention services delivered during July-December 1978 dropped to 52% of the delivery level during the same period in 1977.

B. JUVENILE JUSTICE MENTAL HEALTH

The following is a preliminary analysis of the current Juvenile Justice Mental Health system. The needs of the in-custody or dependent child* are numerous and complex and demand ongoing concentrated program planning and development. The present service design is undergoing reassessment through interagency cooperation which should ultimately provide improved, expanded, and more rationally integrated services to the target population.

Within the Mental Health system, the Guidance Clinic is the multidisciplinary program specializing in the diagnosis and treatment of children and their families who come under the jurisdiction of the Juvenile Court and all its "sister" agencies, i.e., Probation, Social Services, Youth Authority, Residential Treatment facilities, group homes, etc. Because of the nature of the client population, the services are unique and specialized. Operationally, through several memoranda of understanding, the Guidance Clinic has the responsibility of defining the child's mental health needs and advising the concerned agencies of ways in which those needs can best be met; thus becoming an advocate for the client's mental and emotional well-being.

Direct Clinical Services

The direct services provided to children, adolescents, and their families are primarily evaluation and treatment.

* Note: This report focuses only on services to children who are under the jurisdiction of Probation Department. On request, additional information is available regarding services to the dependent child (Social Services)

1. Evaluation and requests for recommendations regarding a child's mental health needs are received from several sources:

   a. Court Prefindings - In this instance, a child has come to the attention of the Court because of some acting-out or illegal behavior. Often, such behavior is difficult to translate into legal charges and the evaluation done serves as an informal amicus curiae brief explaining the psychological status of the youngster.

   b. Court Post-findings - This is the most common Court-ordered evaluation and in these instances, the Court is mainly interested in an explanation of a youngster's illegal behavior. Since this evaluation is a comprehensive psychological study, it in fact points out a youngster's mental health needs from this point forward.

   c. Investigation - In these instances, a child's behavior is often so bizarre as to warrant a diagnostic assessment in order to define the immediate psychological/medical needs of the child.

   d. Placement - Here, a child is typically a ward of the Court and a formal out-of-home placement is ordered. The Guidance Clinic again studies the total needs of the youngster and is in a unique position to advise and advocate for the best interest of the youngster.

   e. Institutions (Juvenile Hall, Senior Camp, Chabot Ranch) - In this instance, the Guidance Clinic becomes the in-house mental health service for each institution. Liaisons from the Clinic are assigned to all institutions and provide evaluation and treatment to the residents.

   f. Individual Probation Officers - If an individual probation officer has some difficulty in relating to a particular child, the Clinic will assist the child and officer to better manage the problem. Crisis intervention and emergency care is provided with longer-term treatment often recommended following an evaluation of the total situation.

2. All the above "entry points" are seen as starting points for ongoing treatment if this is in the best interest of the child. TREATMENT of youngsters is available after an evaluation of the situation has been made. Treatment options vary depending on the needs of the child and treatment is provided through a limited range of programs, County-operated or contract.

Areas of Concern

From the viewpoint of the Mental Health system, the single most crucial issue affecting the mental health care of children within the juvenile

justice system is one of interagency cooperation. Seriously troubled children can no longer be perceived as the "property" of any single program. Agencies entrusted with the care and guidance of children must become spokespersons for these youngsters rather than for an agency; indeed, the child must be viewed as the consumer of services rather than a product.

The need for mental health services irrespective of the agency first in contact with the child is overwhelming. On March 6, 1979, this committee surveyed the 37 Alameda County juveniles currently at Napa and Stockton State Hospitals. While all of these children are consumers of mental health services, approximately 70% are wards of the Court and as such are the responsibility of probation officers from the Placement Unit of the Probation Department. Below is an actual breakdown of these children by hospital site and Court wardship.

LOCATION	COURT WARDS	NON-COURT WARDS
Napa Adolescent Unit	13 (68%)	6 (32%)
Napa Children's Unit	10 (67%)	5 (33%)
Stockton State Hospital	3 (100%)	0 (0%)

The complexities of our society are especially evident in the problems presented by our youth. The complex problems of youngsters can no longer be divided between agencies and their respective jurisdictions. Within the present structure, youngsters can move between Social Services (dependent children), the Probation Department (delinquent children), the Courts (youthful offenders), and the Mental Health System (disturbed children).

At any given period of time, the same child with the same problems can become the "property" of several different agencies; agencies that, heretofore, have done little coordinated treatment or planning.

The need for coordinated services development was easily demonstrated by interviewing both Probation Department administrators and Mental Health clinicians, who function as consultants to several programs for juveniles. Each was asked: "Of the children currently at Senior Camp, Chabot Ranch, Juvenile Hall, and the Placement Unit, how many are in need of a secure psychiatric treatment facility and how many need an open residential facility?" The Probation Department administrators felt 22 children need a secure psychiatric facility; the clinicians felt 35 children could benefit from this type of program. Fifty-three (53) children were seen as needing an open residential facility by the administrators; the clinicians felt 47 of the children needed the residential program.

Clearly, the need exists for both the secure psychiatric facility and residential facilities. The success in meeting this goal, however, can only be realized through interagency pooling of

resources and consistent meaningful and ongoing interagency dialogue and planning. This interagency approach within Alameda County was initiated in April, 1979, and is currently being aggressively pursued. Key administrators from Mental Health, Health Care, Probation, Social Services, and the Courts are currently meeting regularly to develop coordinated programs to meet the needs of this target population.

The Children's Advocacy Committee strongly concurs with and supports this effort. The Committee has several recommendations regarding the work and composition of this interagency group. These are:

- Participation on the committee by representatives of the community advisory boards to each of the agencies.
- Involvement of school system representatives.
- Issue of confidentiality of information between agencies must be explored to allow for the best possible treatment for the individual child as well as protecting the rights of the child.

The Children's Advocacy Committee recognizes the complexity of the issues and needs related to children in the Juvenile Justice system and strongly encourages increased focus and attention on the mental health of these children.

C. PILOT CLIENT FEEDBACK STUDY FOR CHILDREN'S SERVICES

This pilot study was conducted at five County-operated outpatient service sites, and as such, does not include any of the contracted programs, many of which serve minority populations, or feedback from clients of other treatment modalities. It is anticipated that this preliminary study and its implications will serve as a springboard for initiation of more extensive investigations in the future.

Introduction

This study was initiated as part of the ongoing evaluation effort to assess and measure relative client satisfaction of mental health services. Although the necessity of early diagnosis and treatment of mental disorders as a preventive measure in the treatment of mental illness is recognized as a priority in the delivery of mental health services, services to children have often been limited. This pilot study (and future studies) will reveal important insights necessary for the development and implementation of more effective and sensitive children's mental health services.

Planning Process

The need for input from a multi-ethnic, multi-disciplinary perspective was immediately recognized and incorporated in the original study design. Specifically, this involvement included: Children's Advocacy

Committee and antecedent affiliate committees, private providers, League of Women Voters, consumers, clinical staff, Administration and Program Evaluation staff.

Program Evaluation staff devised several preliminary drafts of the client feedback questionnaire. Through a series of meetings, each group was formally requested to review the questionnaire and provide comments and recommendations. These comments and suggestions were then considered in the development of the final instrument.

Methodology

The Client Feedback Pilot Study was conducted at five Alameda County outpatient service sites. Contracted children's programs were not included at this time in order to allow for a testing of the instrument as well as resource constraints. The sample consisted of all onsite outpatient clients (excluding only first client visits) seen from April 2 to April 12. It should be noted, however, that clients included in this pilot study are not randomly selected from the Center caseloads, and the approximate two-week sample may not accurately represent the Center's active ongoing caseloads. The aggregate active caseload of the above clinics is approximately 180 clients.

The procedures outlined below were applied at each site:

- Clients were asked to complete a client feedback questionnaire when they first arrived at the service.
- Clients were asked to complete the questionnaire in the waiting room before their appointments, and to return the questionnaire to the clerk who placed them in a confidential container.
- Clients were instructed not to sign their names.
- Clinical staff members were informed that the survey was taking place, and asked to cooperate should clients need additional time to finish the questionnaire.
- Clerks were instructed that "other than requesting clients to fill out a questionnaire, information given and contact with clients should be as similar as possible to their usual routine."
- Questionnaires were available in English and Spanish.

Specific Findings

Forty-six clients participated in this study and some general demographic characteristics of these clients are presented below:

- As expected, the majority of parent clients are female with a mean age of 31 years. Sixty-three percent of parent/guardians are white, while the second largest percentage is represented by Blacks, 13 percent.

- Also, as anticipated, the majority of children seen are male, 69%. Females represent only 26%. The mean age for children is around 11 years. Consistent with above patterns, Whites also constitute a majority of children's ethnicity, 55% and Blacks make up 14%.

- Length of time in treatment averages around eight months on caseload concomitant with approximately three patients visits per month.

The populations represented at the Centers during the week of the survey includes an overwhelming amount of Whites. Blacks make up the second largest group while others are negligible. This phenomenon is not unexpected nor is it unusual. An investigation of data reveals that most of the 13% of Blacks are from North Region Child/Family Service. A small proportion were from Alameda Children's Service. These two services are the only County-operated outpatient children services in the North Region. County census data indicates that the majority of Blacks in particular, and other minorities in general, reside in the North Region, where contracted, ethnic-group specific services are available (Again, these contracted programs were not included in this initial pilot study, but will be at a later date). Three of the five sample sites, Valley, Tri-City, and Eden, are in the South Region. This affected the total numbers, and, interpreting what the racially specific findings mean, site differences should be remembered.

Future follow-up studies of this nature must focus on feedback from Asian, Black, and Hispanic clients since these groups were underrepresented in this pilot sample. In addition, a randomized sampling of clients who continually fail to maintain appointments would be useful in providing a more composite perspective on client feedback. Particularly, since the literature in this area generally indicates that clients are predictably "satisfied" and the valid applicability of such data has been, for the most part, limited.

*Question 2: Who is regularly seen at this Agency?

The preliminary findings reveal that Fathers are not involved with therapy very much. Specific reasons are unclear. The fact that fathers work is not a sufficient explanation since more and more mothers are also working nowadays. One possible explanation may be single parents; however, this is unproven.

*Question 3: Have you discussed your child's/family treatment plan with the primary therapist? Do you know what is expected from the treatment plan your child is currently on?

90% indicated that they had discussed their treatment plan with the primary therapist. 86% suggested they were aware of the current expectations of the treatment plan. These statistics are impressive inasmuch as they reveal that clients indeed perceive themselves as both involved with treatment plan and are aware of their respective intent. However, perhaps clients who are not involved with their own treatment plan are more likely to not maintain apppointments as well as manifest a different perspective on feedback.

*Question 8: Are you being charged a fee for your treatment services at this Agency?

It was unexpected that 74% responded that they were, in fact, being charged a fee for service. One possible explanation may be that most of the respondents were from the South Region which has a much greater ability to purchase services than the North Region. One might also assume that perhaps the many poorer clients are being served through private clinicians using Medi-Cal. These explanations, however, are speculative and remain to be factually documented by appropriate investigations.

*Question 11: Do you prefer your child's therapist to be of the same ethnic background?

75% reported that it "didn't matter." This would seem to suggest that racial preference for therapist among clients may not be as high as previously anticipated. If this is an accurate reading, therapists may be able to de-emphasize race during therapy, and instead, concentrate on the person. It should be noted, however, that this is not sufficient reason to minimize the necessity for bicultural/bilingual staff. Perhaps clients who do not utilize available services fail to do so because of apparent preferences for bicultural staff.

*Question 13: Would you like someone to contact your family after treatment has discontinued?

66% reported that they would find it helpful for staff to contact the family after treatment is discontinued. This rather strongly suggests that clients favor follow-up contact by staff. This is particularly important since staff generally show propensity for not contacting patients after treatment for fear of resurfacing old problems. Since these clients are all currently undergoing treatment, it would be interesting to know if their attitude would change after treatment has discontinued.

*Question 14: Would you like to have other family members or someone close to your family involved in your family's therapy at this service?

35% reported that they would like other family members involved with their treatment. Specific family members included: father, brother, sister, aunt, uncle, etc. Although an accurate correlation is not clear from the available data, it is significant that a sizable percentage of mothers would like to involve other family members in their treatment.

*Question 17: Has there been anything that particularly pleases you about this Agency?

89% of the clients responded to this question. A representative sampling of specific responses are categorized in the following groupings:

A. Facility

"Friendly, quiet atmosphere."
"Convenient to bus transportation."

B. Staff

"Everyone is extremely pleasant and understanding."
"Staff seems genuinely anxious to help in any way they can, they have very positive attitudes."
"Total empathy on part of staff. I have benefited immensely from this service."

C. Coping Ability

"I don't know how I would manage without the clinic. I don't know I managed before the clinic -- yes, I do know, very poorly."
"This clinic has literally given me a new life. I hope these programs continue to help those like me and my child. The Center is responsible for my son and my improvement in coping with divorce and severe family problems. The Center has more than done its job for me! May it continue!
"It gives me a place to release daily frustrations."

D. Fee Arrangements

"It helps people like myself who need the care and assistance of qualified professionals of which ordinarily I could not afford."
"What pleases me the most is the understanding arrangement regarding fees."

* Note: A recognized gap in the instrument design is the absence of a question regarding overt negative or critical perceptions of the services. This will be included in subsequent instrument designs.

*Questions 18 and 19: How convenient do you find the location of the Clinic to your needs? And how convenient are the hours at this Clinic?

75% replied that the Clinic location was very convenient to their needs. Similarly, 69% indicated that clinic hours were very convenient. This is especially significant in regards to overall centers accessibility and availability of services. On the basis of this data, it would appear that clients are relatively pleased.

* Note: The aggregate findings for the client feedback questionnaire are available upon request.

IV. SUMMARY OF RECOMMENDATIONS FOR CHILDREN'S SERVICES (NOT PRIORITIZED)

A. Reassign one individual to be responsible for crucial administrative liaison to the State Department of Mental Health, the State hospitals, other County, public and private agencies, and the community groups as well as for concentrated planning and evaluation efforts.

B. Analyze the allocation of resources (fiscal and personnel) to begin moving toward conformity with levels of services recommended in AB 1339.

C. Address immediately the critical need for residential and day treatment services for children and adolescents.

D. Continue and expand the interagency committee examining issues and service needs in the Juvenile Justice/Mental Health area, with particular emphasis on the following concerns:

1. Community advisory board participation on this committee.
2. Involvement of school system representation (from both North and South Regions) on this committee.
3. An examination and clarification of the confidentiality concerns between the agencies.

E. Conduct a survey of Mental Health clinicians working in the Juvenile Justice Mental Health field to assess from their perspective what services are needed by the client population.

F. Initiate more extensive client feedback studies for children's services including:

1. Survey of additional service sites, County-operated and contract.
2. Investigate feasibility of feedback survey of children, especially adolescents.
3. Analyze school survey conducted by Children's Advocacy Committee.

G. Improve data collection capability regarding Children's Services within Mental Health system.

AD HOC PLAN COMMITTEE'S ADDITIONAL COMMENTS:

In addition to interagency cooperation and planning for services, the importance of interagency funding for programs must be emphasized. In light of the fact that over 2/3 of the children at Napa are from Probation, the Mental Health Services should examine the current expenditure of only mental health resources for their care.

The needs of minority children and families must be of primary concern in the current delivery of services as well as future programs.

CRIMINAL JUSTICE MENTAL HEALTH

I. INTRODUCTION AND BACKGROUND

The Mental Health Advisory Board's Subcommittee on Criminal Justice functions as the planning committee for Alameda County Criminal Justice Mental Health Services and has been an active and ongoing committee since January 1977. Among the participants on this committee are: representatives from the Alameda County Sheriff's Department, the Public Defender's Office, Office of Court Services, Office of Continuing Care, Probation Department, police department representatives, State Department of Corrections and concerned citizens.

Before describing this year's planning process and work it will be helpful to define the population served by the Criminal Justice Mental Health services. Although often reflecting a wide variability in terms of seriousness of offense, severity of mental illness, and degree of sociopathy or commitment to criminal life style, most Criminal Justice Mental Health clients can be described as chronically dysfunctional individuals. More specifically, these clients are often characterized by long histories of unemployment with minimal or non-existent work skills, frequent entanglements with the law, consistently poor judgment in the management of their finances, impaired social and interpersonal relationships, history of drug and alcohol abuse, and long-standing emotional or mental problems resulting in multiple hospitalizations for some, and at least prior mental health contact for others. More often than not, these clients minimize, deny, or externalize responsibility for their problems, and demonstrate a poor track record in following through with programs or treatment plans designed to reverse their dysfunctional behavior once released back into the community. Although some individuals will remain incarcerated for several months, or perhaps years, most will be returned to the community.

During the initial phase of this three-part planning process, this committee conducted a needs assessment of the criminal justice mental health population. Four major goals were identified. These were:

1. The development of a local secure psychiatric inpatient unit for the care and treatment of 4011.6* defendants;

2. The development of a case management service responsible for the continued care of 4011.6 clients returned to the community;

3. Improved "diversion" procedures for the mentally ill clients caught up in the correctional system, and;

4. Active mental health planning in the design of all new jail facilities, specifically the creation of "soft jails" within all new jails.

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*This refers to section 4011.6 which enables psychiatric evaluation for in-custody clients.

Additionally, Mental Health Administration recognizes the specialized needs of the disproportionate numbers of minority clients within the Criminal Justice Mental Health system. Efforts continue to bolster the recruitment of minority staff as well as the development of a forensic Civil Service specialty classification.

Throughout the succeeding year, specific proposals aimed at implementation of the above-stated goals were submitted to the committee and with the aid, support, and constructive feedback of this committee, considerable progress has occurred. Specifically:

1. A plan for the combined inpatient/outpatient unit at Fairmont Hospital was submitted, and a 16-bed unit was established at a temporary location of C-2, Highland Hospital;

2. Proposals and plans for a case management service were also identified and reviewed and although not fully implemented, a small pilot project providing case management services to approximately 6 - 10 4011.6 clients discharged from C-2 has begun;

3. Negotiations and discussions, aimed at expanded jail mental health services (e.g., "soft jail") in the new Oakland facility and in the planned new post-sentenced facility at Santa Rita, are in progress between the Sheriff's and Mental Health Departments.

4. In addition, the OCC-MDO Unit has effectively established liaison with five residential care facilities that are now willing to provide residential care and treatment to the criminal justice population;

5. Plans for formal liaison, between Parole, Parole Outpatient Clinic, and County Mental Health Services, aimed at improved identification and coordination of treatment for mentally ill clients coming out of prisons, are also near completion; and, finally;

6. A study regarding the experiences of the police officer on the street in dealing with mental health clients, was reviewed by our committee and this report has served as a catalyst for improved relationships between Highland Psychiatric Emergency Service and the Oakland Police Department.

There were some setbacks, however, notably our inability to fully implement a case management system and our failure to reach any formal understanding between the offices of the Public Defender, District Attorney, and Mental Health regarding the "diversion" of mentally ill clients from the criminal justice system. Fiscal constraints due to Proposition 13 and policy issues regarding the use of OCC-MDO staff for 4011.6 clients largely limited the first, and a basic disagreement regarding the sharing and exchange of information has delayed the second.

In addition, our initial plans to establish a 20-bed male/female unit at Fairmont Hospital fell through due to unforeseen structural inadequacies of the proposed site. An alternative plan, calling for the shift and expansion of our C-2 unit to 8-East, Highland, has been submitted and is awaiting cost estimation. This would expand the unit to a potential 24 beds and allow for the inclusion of female defendants.

II. TASK AND APPROACH

Our task this year was to evaluate services developed or identified as being essential to the care and treatment of the criminal justice mentally ill client. The committee decided to focus on the 16-bed CJPIS* because:

1. Much of the concern and time of our committee has been spent on the development of this unit and a review, after its first year of operation, seemed appropriate;

2. Although the unit was not established as a "diversion" mechanism, it was expected that a local secure inpatient facility would improve both our communications and relationship to court services, thereby aiding clients better served through mental health services;

3. An internal annual review had already been developed thus making data available to the committee for its review and analysis.

A major limitation of the service is that C-2 serves male defendants only. Female defendants are temporarily treated on the regular Psychiatric Inpatient units at Highland. Attempts at addressing the need for equal treatment for female defendants has been dealt with by the development of a specialized treatment team for female defendants on these regular units. But data on female defendants, comparable to that which is summarized in this report, is not available. The following analysis of results is a summary of the material received by the committee. The complete report is available upon request.

III. RESULTS

A. DISPOSITION DATA

Dispositions were examined to identify the level of mental health involvement following discharge from CJPIS. Six categories of dispositions were defined as follows:

1. Jail: Primarily Santa Rita, but also including custody in other jurisdictions.

2. State Hospital: Napa and Atascadero State Hospitals.

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* CJPIS: Criminal Justice Psychiatric Inpatient Services

3. Community Hospital: Out-of-custody placement in inpatient treatment at Highland, V.A., or private hospitals.

4. Community Mental Health Facilities: Out-of-custody referrals to community mental health programs -- outpatient clinics, halfway houses, long-term treatment facilities, and specialized drug and alcohol treatment programs.

5. Self: Out-of-custody discharge care of self with recommendations of private or community mental health follow-up.

42.1% of evaluation referrals returned to jail. The vast majority of these patients received follow-up treatment through the CJ Outpatient Unit. A second sizable percentage (23.4%) were transferred to the State hospital for long-term treatment. Although these patients continued under the control of the courts as penal code commitments, or under the indirect jurisdiction of ACSD, few actually returned to the jail setting. Excluding the disposition "Other", 34.1% of the evaluation referrals were diverted from custody. When this group is combined with the State hospital transfers, a total of 57.5% of the patients were diverted into appropriate services. The 0.5% of the "Other" category represented two patients who escaped from the unit.

Inspection of the dispositions for boarders (clients referred for holding while waiting for court appearances) reveals that the vast majority (78.4%) were returned to the State hospital. A small percentage (12.2%) however, were diverted to community treatment, while 9.4% were returned to jail. This latter percentage provides a rough index of the proportion of State hospital transfers that return to the jail setting. A longer period of evaluation will more reliably determine this number.

The disposition data reveals the following findings when ethnic groups are compared. Black patients are returned to jail significantly more often than White patients and others (52.1% Black vs. 32.4% White vs. 22.2% Other). In addition, Black patients were transferred to the State hospital less often than the other groups (19.4% Black vs. 24.7% White vs. 55.6% Other). Thus, a lower percentage of Black patients were diverted to community services in comparison with White patients (27.9% vs. 42.3%). Explanation may be found in several other factors:

1. Prior criminal history may have distinguished the groups and limited the diversion options the staff could achieve with the courts.

2. Differences in referrals for court-ordered evaluations (4011.6 PC) may have distinguished the groups. White patients with charges more likely to lead to mental health diversion may have been

referred more frequently than was the case for Blacks.

3. The courts may also have been less inclined to accept recommendations for mental health placements for Black patients than for White patients given similar circumstances.

4. The staff may make assumptions that Black patients can better handle the environment at Santa Rita, which houses predominantly Black inmates.

5. Diagnosis only categorized individuals, it fails to determine need for inpatient care; only symptomatology does that.

6. A myriad of other variables that our selective data does not include or analyze.

The above analysis of statistics elucidates the characteristics of the population of patients that are treated by CJPIS. Clearly, that service has diverted a majority of patients who previously may have remained in the criminal justice system. The unit has fulfilled its mandate to treat psychiatrically impaired male CJ patients locally, and it has reduced the number of admissions of CJ patients to Napa.

B. IMPACT ON NAPA STATE HOSPITAL UTILIZATION

A prime motivator in the establishment of the Criminal Justice Inpatient Service was to reduce the high utilization of Napa State Hospital beds by Alameda County 4011.6 patients. As Table I* indicates, Alameda County Mental Health Service averaged forty-one 4011.6 admissions per month to Napa State Hospital from June 1976 to to February 1977. This corresponds to the time period in which Alameda County sent all its 4011.6 hospital referrals directly to Napa. Napa's 4011.6 census during that period averaged 57 patient/day. In March of 1977, Napa State Hospital revised its admission policy to exclude 4011.6 clients with high bail (in excess of $10,000) or potential escape risks. Thereafter, and until the CJPIS opened in January of 1978, all 4011.6 clients had to be screened via telephone prior to admission to Napa. This resulted in a rejection rate of 45% and reduced Napa State Hospital admissions to 17/month, and added a Highland General Hospital admission rate of 14/month. The total 4011.6 census at Napa was reduced to an average of 46 patient/beds/day.

Since the opening of the unit, CJPIS has averaged 8.6 total admissions/month to Napa, and an average of 6 patients/month when only new admissions are included (i.e., excluding boarders returned to Napa). The 4011.6 census at Napa has subsequently dropped to an average 24 patient/days at Napa, if you grant a three-month start-up date (i.e., data is compiled since April 1978), or 22 patient/day average over the last four months. Although no data is presented here on legal status of 4011.6 patients sent to Napa, referrals are

*See Page II-28

generally restricted to patients who are chronically disabled or unable to cope with local jail environment no matter what supports are available.

Total impact of hospital utilization is reflected in Table II*, which shows a reduction in Napa beds from a peak of 20,805 hospital days during November 1976 to February 1977, to 8,030 days, based on current use over the past four months. This has occurred in spite of the fact that the unit is functioning at only 80% of bed capacity (16 beds vs. proposed 20 beds).

In terms of our stated objectives, the unit has effectively eliminated direct admissions of 4011.6 patients to Napa, and has currently reduced the 4011.6 admission rate by 85% and our 4011.6 hospital utilization days by 12,775 days/year from the peak periods of November 1976 to February 1977.

Overall, the reaction to and perception of the C-2 unit is highly favorable. It is perceived as a well-organized, clinically sound program with dedicated staff meeting administrative objectives and providing quality care.

IV. SUMMARY OF RECOMMENDATIONS FOR CRIMINAL JUSTICE MENTAL HEALTH (not prioritized)

A. The need for a facility capable of housing and treating both male and female defendants remains one of the committee's primary concerns. In this vein, this committee will continue to support the proposed move to 8-East.

B. Request for further clarification and study regarding the differential dispositions between Black and White defendants has been made by the committee. In response to this, an expanded study is in progress and the results, when available, will be shared with the committee. This is a conjunct to ongoing affirmative action efforts and the forensic specialist classification.

C. The major focus of our committee now shifts to the need for expanded aftercare services and an improved system of identifying the mental health needs of jail inmates. A request will be made to include the criminal justice population in the client feedback survey being developed through the Planning Office.

D. A re-examination of the needs and resources available for a case management service must be given top priority.

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*See Page II-29

E. Other recommendations include a review of existing community residential facilities and, with the building of the new jail facilities, a review of our procedures and methods of both identifying and serving the 4011.6 and 4011.8 clients.

V. POSITION PAPER ON COMPREHENSIVE CRIMINAL JUSTICE MENTAL HEALTH SYSTEM

The following is a portion of a statement prepared by the Alameda County Special Projects Director, describing the components of a comprehensive service delivery system for the clients seen by the criminal justice mental health service units. It is presented here as a long-range statement of need.

BASIC PREMISES OF PLAN

One premise of this plan is that the needs of the individual criminal justice clients can vary considerably during the course or episode of an illness, and that, despite the many common characteristics, there are no simple, uniform criminal justice mental health clients that can be easily addressed through the development of one or two services. Consequently, a successful criminal justice mental health system must have a spectrum of services so that the needs of the clients determine the course of treatment rather than just the availability of existing resources. This allows services to do what they are best designed to do and helps avoid the pitfalls of trying to do everything and ending up doing nothing. For example, a "soft jail", as explained in this paper, refers to the availability of designated cells within the jail in which the identified mentally ill clients can be segregated from the rest of the prison population and provided with closer supervision, greater access to psychiatric intervention, and a less stressful environment than is other wise available to them. A "soft jail" then serves as a resource for the marginally functioning individuals that are either just released from the hospital or for clients who would decompensate and require hospitalization if left in the normal jail setting.

If properly designed, and with sufficient support services, this unit should be able to significantly improve the conditions of the mentally ill in-custody clients and help reduce both the number of patients hospitalized and the average length of the hospital stay. This unit, however, is not and cannot function as a cheap and convenient in-jail hospital. To use it as such would force the marginal client out and back into the regular cells and admit the disturbed client, only to warehouse him. It would then serve neither its intended purpose nor any substitute purpose satisfactorily.

The second premise is that the building of a criminal justice mental health system must be a progressive process in which the core services, that is, evaluation and treatment units for in-custody clients, the short-term acute psychiatric hospitals, and a community aftercare pro-

gram, must be developed first. These core services are the most crucial services in that they either treat the largest percentage of clients, as in the screening unit, or the most disturbed, as in the acute hospital, or that they make other parts of the system work, as in the aftercare program. In addition, they serve to identify and clarify additional needs, which becomes the justification for expanding the spectrum of services to include resources like "soft jails", halfway houses, etc. As an example, some diversion potential is essential for a complete system, but the successful ability to divert appropriate clients requires first, the existence of a screening and evaluation unit to identify the alternative community resources and to facilitate the individual's connection to them. A "soft jail" is similarly dependent upon the screening and evaluation unit, as well as a short-term hospital; and residential care facilities are obviously dependent upon a viable aftercare unit. Adequate data should be kept to insure justification of both existing programs and proposed expansion to all phases of development.

In summary, the planning and building process for a criminal justice mental health system has to be a flexible and realistic one. It must start with an accurate assessment of the existing correctional resources, proceed with a recognition of the diversity of the needs of the criminal justice population, and a commitment to a spectrum of services to meet those needs; then it must prioritize these needs so as to focus development on the core services. Once the basic services are established, additional programs should then be added, creating a comprehensive service delivery system.

DESCRIPTION OF SERVICES

A. Initial Screening and Identification Service:

Essentially, this is a mechanism or service to insure that criminal justice clients in need of mental health services are quickly identified and referred to a screening and treatment unit. To operationalize this may require hiring psychiatric techniques or mental health workers on a 24-hour basis, or at key booking times, to do brief screening or interviews of newly incarcerated individuals. Alternatively and perhaps more productively, it can be addressed through educating existing correctional staff on recognizing signs of mental illness or severe stress, or by adding psychiatric nurses to existing medical detention unit to aid in the initial screening of patients. The justification for creating a separate unit to screen all in-custody clients is based on the assumption that the current system of relying on existing correctional staff, judges, and medical detention staff to identify clients in need of mental health services is inadequate. This may not be true. Transportation problems, attitudenal differences, or lack of treatment resources may be greater deterrents to clients being referred for evaluation than any shortcomings in the process of

identifying clients in need.

B. In-Custody Screening, Evaluation, and Treatment Unit

This is probably the most crucial mental health service available or needed by the criminal justice population and it refers to a combined psychiatric emergency/direct-service clinic for in-custody clients. Most services are located within the jail, but some, including Alameda's, are located in other settings. This service has the responsibility to evaluate all patients referred under 4011.6 or 4011.8 by the courts, jails, police departments, or clients, and determine the need for inpatient treatment and/or medication and counseling. If treatment is needed, this service would provide any necessary non-hospital treatment while the client remains in custody. In addition, it has responsibility for making disposition recommendations to the courts, and serves as the center point in development of a total mental health system. To be effective, a rich professional staff is necessary.

C. "Soft Jail"

This refers to designated cells within the jail where identified mentally ill defendants can be segregated from the rest of the prisoner population and provided with closer supervision, a less stressful enviornment, and greater accessibility to psychiatric intervention. This unit would remain as part of the jail under the jurisdiction of the Sheriff's Department. Mental health Staff would provide the psychiatric observation and any "on site" direct services, as well as assuming responsibility for screening clients in and out of this unit. The "soft jail" would serve as a buffer zone between the hospital and the regular jail for the "at risk" patients, either in terms of decompensation or suicide. It is anticipated that such a resource would improve the conditions of the mentally ill within the jails, avoid some costly hospitalizations, and shorten the length of hospitalization for still other clients.

D. Short-term Psychiatric Acute Hospital

The need for acute psychiatric beds for criminal justice clients is well documented in every urban county. No matter how well designed or staffed a jail may be, incarceration does not negate the need for hospitalization. In Alameda County alone, twenty to thirty criminal justice patients are referred for hospitalization under LPS each month. These patients have specialized problems (security, legal entanglements, increased potential for violence, etc.) that cannot be met through referrals to State hospitals or inclusion in existing non-criminal justice psychiatric units. It is also important to stress that what we are talking about here is a hospital with security, and not a jail with a hospital. Unlike the "soft jail", the control of this facility, except for perimeter security, should be under mental health hospital staff.

E. Access to Long-term Hospitalization

Even with adequate short-term acute psychiatric beds, there will always be some client in need of long-term hospital care. Traditionally, State hospitals have served this need. If the general State hospitals close (e.g., Napa State Hospital), Atascadero will be the only long-term facility available to the more chronic mentally ill criminal justice clients. Presently, Atascadero is used only for the more serious offenders, and it would be poor policy to refer the chronically disturbed, but non-dangerous or non-security risk patient to this facility. Thus, a comprehensive system must have access to appropriate long-term facilities. If diversion mechanisms are available, it is possible to make use of conservatorship or local long-term alternatives, e.g. patched-SNIF with special programs, for the "non-dangerous" population. If patients cannot be diverted and/or if Atascadero also closes its doors as a referral source, then alternatives must be built within the large urban counties or on a regional basis. Within Alameda County, there has been some discussion as to the advisability of including an additional 20 to 25 bed long-term care ward adjacent to the psychiatric acute ward to serve this purpose.

F. Diversion

Every county should have the capacity to divert select in-custody criminal justice clients into existing community mental health resources. The responsibility for the development of such a procedure would lie primarily with the courts, the district attorney, and the public defender. Mental health would retain the responsibility of making the initial evaluation and identifying clients who, on the basis of their mental illness, could benefit more from community treatment than correctional incarceration. The DA and the courts would then determine whether or not the current charges or the client's past history of arrests and offenses (i.e., his "dangerousness") justifies his release to the community.

G. Community Aftercare Unit

One of the most glaring gaps in our current mental health system is the absence of any identifiable unit to work with the 4011.6 population once released from custody. This population has multiple problems and is extremely difficult to manage once in the community. Most board and care homes and half-way houses will not accept them, outpatient clinics are reluctant to take them, they are often released to the community without any immediate resources (funds, housing, etc.) and finally, they, themselves frequently resist or refuse the services that are available. What is needed is a clearly defined community aftercare unit that has responsibility to:

1. Maintain a liaison and accept referrals from the existing Criminal Justice Mental Helath Service Unit, and the acute and long-term hospitals;

2. Identify, promote, and support the development of community resources;

3. Provide placement services as indicated;

4. Provide case management services to clients, as needed, and to facilitate the connection of clients to appropriate community services, and;

5. To provide direct services when specialized services are needed and are not available elsewhere, or on a short-term crisis basis until clients can be connected with existing mental health services.

This unit should combine the resources currently funded through AB-1229 and OCC* (parolees from judicial commitments) with some additional funding to form one, integrated unit. This would serve to minimize duplicity of effort, coordinate development of resources, allow for increased flexibility of staff to meet changing needs, and improve and clarify liaison and referral relationships within a very complex correctional system.

H. Residential Care Facilities

Most existing residential care facilities are reluctant to accept any clients with recent history of arrest or violence. In addition, many criminal justice clients want only temporary, emergency housing and are reluctant or refuse to make the time commitment frequently required by half-way houses and board and care operators. Consequently, the following types of residential facilities are needed:

1. Short-term emergency housing: This would be a crisis house where clients could stay up to two weeks until more permanent housing could be worked out. Counseling would be available, and clients would be provided by the Aftercare Unit.

2. Half-way House: This probably could be modeled after the traditional half-way house, where clients stay 6 to 9 months, and are involved in complete treatment programs. Again, clients would be accepted on referral only, and the Aftercare Unit would provide back-up and support. Staffing would be 24 hours, with some professional staff available.

3. Specialized board and care homes: Many criminal justice clients are no different than the generalized mentally ill population and, as such, are appropriate for placement into board and care homes.

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* OCC: Office of Continuing Care

Unfortunately, most operators are reluctant to accept this population due to their recent arrest or past convictions, and some incentive is needed to encourage their cooperation. Presumably, a viable aftercare unit would be able to provide increased support services as an inducement to accept these clients. Some financial inducement, however, would probably create more enthusiasm and would allow for greater selectivity in the choice of homes. This could be accomplished by establishing differential rates for board and care homes according to level of care or problems of population served.

TABLE I

ALAMEDA COUNTY NAPA ADMISSION DATA -- 4011.6 PATIENTS

Month	Napa Adm/Mo*	Napa Average Daily Census*	Highland Adm/Mo.
July 1976	41		
August 1976	48	No Data	
Sept. 1976	62	Available	
Oct. 1976	43		
Nov. 1976	41	52	
Dec. 1976	28	56	
Jan. 1977	34	59	
Feb. 1977	29	60	
AVERAGES	41	57	
March 1977	20	55	13
April 1977	34	44	0
May 1977	24	42	16
June 1977	11	46	11
July 1977	9	43	14
August 1977	22	41	12
Sept. 1977	19	49	18
Oct. 1977	18	45	14
Nov. 1977	8	47	17
Dec. 1977	6	47	25
AVERAGES	17	46	14
Jan. 1978	7	47	
Feb. 1978	3	37	
March 1978	10	34	
April 1978	8	30	
May 1978	7	25	
June 1978	15	27	
July 1978	10	21	
August 1978	15	25	
Sept. 1978	12	29	
Oct. 1978	8	25	
Nov. 1978	6	21	
Dec. 1978	7	22	
Jan. 1979	5	23	
Feb. 1979	8	21	
AVERAGE	8.6 6.0 when boarders ret'd to Napa are excluded	29 since opening 24 granting 3-month start-up time 22 last four months	

*Figures include both male and female defendants

TABLE II

Napa State Hospital Utilization Rate

Time Period	Average Daily Census	Utilization Rate Days/Year (Based on average x 365)
November 1976 to February 1976	57	20,305 days
March 1977 to December 1977	46	16,790 days
*January 1978 to March 1978	29	10,585 days
April 1978 to February 1979	24	8,760 days
November 1978 to February 1979	22	8,030 days

*Opening of CJPIS (C-2)

ADULT CONTINUING CARE

(Including Progress Report on Elderly)

I. INTRODUCTION AND BACKGROUND

Substantial effort has been and is being expanded within the Alameda County Mental Health system to improve, expand, and develop the local alternatives for persons previously receiving treatment only at the state hospitals. In continuously reducing the dependence on hospital-based care, priority for program development is given to:

a) Those persons with a history of psychiatric hospitalization at either state or local, public, or private facilities.
b) Those persons never hospitalized, but at risk of requiring such care if appropriate services are not available.

The struggle to develop an appropriate, accessible, and sensitive continuing care system has taken many forms and addresses a variety of issues. Efforts such as case management, quality assurance, workload standards, medication monitoring, day-programming, minority program contracts, affirmative action, community support, interagency cooperation, all address the highest priority need identified in the needs assessment, i.e., improved and expanded services to the chronically mentally disordered adult. Services development ranges from plans for a 99-bed L-facility to improved outreach (See Table of Contents for summary of projected new and expanded programs) and must be responsive to the needs of a variety of populations; ethnic minorities, sexual minorities, the elderly, young adults, to name a few.

Many of these needs are discussed and described in previous plans. Too many are, as yet, unmet or inadequately addressed. The importance of an overall, system-wide continuing care plan can not be understated, and is of utmost concern to Alameda County Mental Health Services.

Obviously, the Adult Continuing Care Planning Committee was unable to evaluate or even discuss all of the needs of the adult mental health client. This report must be seen within the context of the wide range of ongoing and planned efforts to improve services to the priority population.

The Adult Continuing Care Planning Committee has a membership of over 30 individuals representing the Mental Health Advisory Board, current and former consumers, Mental Health Association Board members and staff, contract services staff, private practitioners, and Alameda County mental health staff.

II. TASK AND APPROACH

After much discussion, the committee selected several tasks for this year's planning effort.

A. The conducting of site visits at two 24-hour facilities that are currently utilized by the acutely ill adult population: Canyon Manor, a contract skilled nursing facility; and Highland General Hospital, the county-operated psychiatric services.

B. The assessment of the role and tasks of the Patient's Rights Advocacy office in Alameda County.

C. A description of the recently implemented case management system.

D. A progress report on efforts to address the mental health needs of the elderly population.

III. RESULTS

A. FACILITY SITE VISITS

In preparation for the site visits, the draft of an instrument developed by the Mental Health Association of Alameda County was used as a reference. This instrument, titled "24-Hour Inpatient and Residential Facilities", from the Manual for Citizen Assessment of Public Mental Health Service, outlines subject areas for citizens to use in evaluation and/or monitoring of facilities.

The areas selected to guide the visits were:

1. Food and clothing.
2. Quality of the building.
3. Assault and protection -- how safe are patients and staff, how safe is the assaultive client, what training has staff had in handling assaultive behavior.
4. Restraint procedures.
5. Privacy and security of personal belongings.
6. Protection of rights.
7. Activity programs.
8. Medication procedures and policies.
9. Patient and/or staff abuse, such as sexual harrassment, use of restraints, racial discrimination.

In reading the results of the site visits, some considerations must be kept in mind.

a. Available time and resources seriously limited the documentation of findings, as well as the accuracy of observations, conclusions, or recommendations resulting from the visits.
b. Comparisons between the facilities should not be made. Canyon Manor is a skilled nursing facility contracted by Alameda County to provide services to selected clients for whom this type of facility is most appropriate. Highland, on the other hand, is

an acute care hospital-based facility providing emergency, screening/evaluation, referral, and in-patient services. The intended purposes of the two sites, lengths of stay, the populations they serve, the presenting condition of the clients, the physical plants, and the circumstances in which they exist are quite different.

c. The findings have been summarized.
d. The members of the site visit teams were different, so that the perceptions may differ.
e. Valuable experience resulted regarding the conducting of site visits with citizens, consumers, mental health professionals, and staff participating, with all expressing interest in further planning and evaluation efforts.

For the purpose of consistency, the site visit findings and comments will be summarized in a format that roughly follows the nine areas of the Mental Health Association instrument discussed above which were used to guide the visits.

1. Canyon Manor Site Visit

Four Plan committee members visited Canyon Manor on February 23, 1979, spending 3.5 hours at the facility and meeting with the treatment staff and clients.

- Physical Plant (Food, clothing, and accomodations)

Canyon Manor was found to be a clean, well-maintained facility; beds were made, rooms were orderly, and adequate security for personal property was provided. One aspect of the physical plant needing improvement is the amount and condition of courtyard space. The sampled meal was "tasty and nutritious," with special diet respected.

- Activity Program

Client observations indicated the need for more available time for occupational therapy activities. In general, the activity and programmatic components should be increased to offer more options for how clients spend their time outside of specific structured programs.

- Patients' Rights

The Marin County location, a middle-class neighborhood with a rural atmosphere, is of concern to committee members. It is inaccessible by public transportation (i.e. 4 to 5 hours via bus) and the environs are dissimilar to metropolitan, industrial Alameda County. Making it difficult, if not impossible, for a client to have visitors of his/her choice may impinge on patients' right and certainly handicaps a client's ability

to actively participate in his/her own discharge planning. The committee suggests that the County might provide a bus service for residents and visitors, yet seriously questions that any facility located such a distance from Alameda County can adequately meet the needs of Alameda County residents.

Another area of special concern to the committee is the under-representation of minority clients and staff at Canyon Manor. It is suggested that an examination be conducted on how referrals are made. This could determine if minority clients are provided an equal opportunity to utilize the County's program at Canyon Manor. It is also strongly urged that the facility actively recruit more minority staff.

- Medications, Seclusion, and Restraints

  The staff person responsible for the distribution of medicines during the site visit reported that staff were conscious of medication issues and some efforts were being made to reduce the levels of medication for patients. Dosages were reported to be within the Physicians' Desk Reference (PDR) standards. It is recommended that clients be provided with written information regarding the side effects of psychotropic medications, and that residents be more involved in decisions regarding medications prescribed.

  Observations also indicated that the use of seclusion and PRN medications seems routinized and that standards for seclusion and PRN medications need review.

2. Highland Hospital Psychiatric Services Site Visit

Five Plan committee members visited three psychiatric units and the Psychiatric Emergency Services (PES) on February 13, 1979, spending approximately 4 hours at the facility and meeting with treatment staff and clients.

Inpatient Units

- Physical Plant (Food, clothing, and accomodations)

  All three inpatient units were found to be clean with adequate living area for clients. Clients appeared physically well-cared for and were dressed in street clothes (with the exception of some Criminal Justice clients who stated a preference for pajamas based on a concern for loss of personal belongings). Some geriatric and physically disabled clients stated a dependence on other clients for some physical needs.

- Activity Program

  Client observations indicated the need for better use of existing occupational and recreational facilities. It is suggested that staff could develop a richer schedule of activities for clients who felt there was "nothing to do" much of the time. This might include, at a minimum, additional reading material, cards, and games.

- Patients' Rights

  Patients' Rights handbooks are available on the wards and the Patients' Rights are posted. It is important, however, for the responsibility for the distribution of these handbooks be clearly delineated as well as more predominantly posting the rights.

  It is also suggested that families and friends be more integrated into the overall treatment of a client. This is a complex issue, but educational programs might be developed to facilitate relatives and friends' understanding of issues regarding mental health promotion, medications, and prognosis, after-care, etc.

- Medication, Seclusion, and Restraints

  Discussion with staff persons regarding medication and dosages indicated a need for guidelines regarding the levels of medication prescribed and closer physicians' observation of clients. One physician reported that he, at times, has prescribed medication exceeding PDR recommendations where clinically indicated. Also, clients and/or relatives and friends need to be provided with written information regarding the use and side effects of psychotropic medications.

Emergency Unit

Additional comments made by the site visit team regarding the psychiatric emergency services (PES) unit are presented below:

- At the time of the site visit, the PES unit was especially busy, with the number of clients exceeding bed capacity. The site team suggested that emergency measures such as roll-away beds is not necessarily the solution, however. The problem may relate more to the need for additional psychosocial resources in the community so as to avoid hospitalization. The crowded PES unit may indicate a need to also explore alternate means of providing for persons in crisis.

- Effective and appropriate use of staff resources should be examined more carefully to ensure staff and client safety.

Although quite busy, the staff's interaction with clients seemed too infrequent, with much time being spent in the nurses' station. Again, more staff may be needed in PES, although crisis-service delivery alternatives should be explored.

- Restraints used in PES need to be repaired or replaced. Ragged or rough edges might be abrasive to the client's skin.

- Because clients in PES are not considered admitted to the hospital, Patients' Rights handbooks are not distributed. This is an area of concern that the Patients' Rights subcommittee may want to examine.

- Standards and medication monitoring procedures developed for the inpatient units should also be adapted to medication practices employed in the PES.

B. PATIENTS' RIGHTS ACTIVITIES PLAN

Adult Plan committee members and mental health staff met with the Alameda County Patients' Right Advocate, who described the approaches used to ensure that patients are able to exercise their rights as described in the Title XX regulations.

In addition to this meeting, the group reached the following findings and recommendations from surveys of a diverse group of individuals who have frequent contact with the Office of Patients' Rights Advocate and a concern for knowledge of issues regarding patients' rights.

The following evaluation plan of Patients' Rights in Alameda County consists of:

1) Purposes of the evaluation;
2) Findings of the initial observations; and,
3) Processes for evaluation.

Purposes

- To evaluate the implementation of Patients' Rights' Title XX regulations in mental health facilities.
- To gather recommendations for constructive change.
- To obtain client/patient feedback regarding effectiveness of the implementation of Title XX.
- To assist and advise the Patients' Rights Advocate on the implementation of Title XX and to help identify resources for the carrying out of Patients' Rights activities.
- To determine the need for monitoring Patients' Rights on an ongoing basis.

- To survey and evaluate the current practices, policies, and procedures of involuntary commitment in Alameda County.

Findings

- There is a possible conflict of interest involving the Patients' Rights Advocate being employed by the County.
- There is not enough time for one half-time Advocate in Alameda County to fully implement Title IX.
- The committee felt that there is a lack of knowledge of Patients' Rights among mental health professionals working within institutions and in the community.
- There is inadequate posting and informing patients/clients of their rights.
- There is strong desire among patients/clients, advocates, mental health professionals, etc., for the inclusion of additional, specific duties to the Patients' Rights Advocate role. For example, visiting facilities regularly to monitor the situation and ensure the rights of those patients/clients who are unable to contact the Advocate; acquiring regular patient/client feedback on resolution of complaints.
- There is no information available as to the resolution of complaints handled by the Advocate.
- There is no formal mechanism for client feedback on the resolution of complaints.

The committee would like to continue its work and submits the following plan:

Process

- Survey of former and current patients/clients of the mental health system for feedback on the protection of rights, the role of the Patients' Rights, etc.
- Survey mental health professionals to evaluate levels of knowledge of Patients' Rights regulations and to assess the need and extent of training.
- Visitation of facilities for the purpose of monitoring implementation of Title IX regulations.
- Set up a permanent committee of the Mental Health Advisory Board on Patients' Rights with the representatives of all segments of the mental health community to carry out the above activities. Suggested composition for purposes of these tasks:

  1) Ex-patient groups such as Coalition Against Forced Treatment (C.A.F.T.), Mental Health Consumer Concerns (M.H.C.C.), and Network Against Psychiatric Assault (N.A.P.A.), etc.
  2) Citizens groups such as Mental Health Advisory Board (M.H.A.B.) Mental Health Association (M.H.A.), Families Group, etc.
  3) Mental health professionals such as representatives from 24-hour facilities (public and private), representatives from Alameda County Mental Health Services, etc.
  4) Legal Advocacy groups.
  5) Law enforcement groups such as the Sheriff and local police departments.

C. CASE MANAGEMENT SYSTEM REPORT

In an effort to expand and improve the continuing care system, Alameda County began implementing a case management system in early 1979. The goal of this program, in providing supportive services, is to ensure treatment for clients who have, in the past, failed to utilize inpatient psychiatric services. A comprehensive diagnostic work-up and treatment plan will be established for each person in the program. Linking the client to pertinent services, monitoring progress and advocating on behalf of the client are the key features of the system. The case manager must be available to the client regardless of his/her location or needs.

Special Services has a Facility Liaison component which is designed to provide supervision and monitoring of Alameda County clients who are in psychiatric skilled nursing facilities (most of which are located in other counties). Those clients are identified upon admission and the course of treatment is closely followed. The responsibilities of the Placement Unit relative to locating suitable residential facilities for hospitalized patients continue as present.

Special Services is centrally administered and utilizes existing staff positions which are being transferred into the Placement Unit from County and State services (four from the County, and four from the State Office of Continuing Care -- OCC) It is anticipated about 250 clients will be served by the end of 1979.

Although it would be premature to evaluate this system which has just become operational, an evaluation schema has been developed in conjunction with the implementation of case management.

A citizen's committee has worked with the Agency in the development and implementation of this system. This report is a brief summary of the case management system. The complete plan is available upon request.

D. PROGRESS REPORT ON SERVICES TO THE ELDERLY

1. Background

This progress report marks the first formal statement in the Short/Doyle documenting the existing mental health services to the elderly a statement of need and preliminary plans for meeting those needs. A special task force comprised of inter-agency representatives, a Mental Health Advisory Board member, a representative of the Grey Panthers, Mental Health staff, and Alameda County Department Aging staff convened to develop this report.

The most recent national figures indicate that 15-25% of persons over 65 have significant mental problems* and that only 2-3% of

* Jean D. Coker, Mental Health and the Elderly, Unpublished Issues Paper NIMH Center for the Studies of the Mental Health of the Aging, 1977.

persons over this age receive either public or private mental health care.[1] Of the 5% of the elderly in long-term care, it is estimated that 50-75% are mentally impaired and seldom is any mental health care provided.[2] The suicide rate is highest for persons over 65, with the highest rate being that of males in their 80's.[3] The 1970 census figures for Alameda County indicate that 140,667 or 13% of persons over 60 live in the county with approximately 96,000 living in North County and the remainder, approximately 45,000 living in South County. The latest county mental health figures show that only 0-3% of the total discharges were 65 years old or older.[4]

Recognizing the imperative need for specialized services to the elderly, Alameda County Mental Health Services has currently developed two programs for the elderly. The East Oakland Community Mental Health Center was awarded an NIMH Conversion grant for specialized services to the elderly. This one-year project, terminating November 30, 1979, provides preventive home and protective setting assessment, treatment and case management, and community education to elderly residents in East Oakland. The second specialized program addresses the critical and growing problem of acutely mentally ill elderly persons inappropriately hospitalized at Highland Psychiatric Inpatient. A special unit for the elderly has been established. Often these clients must be maintained on an inpatient unit because of a lack of appropriate community alternatives. These two programs jointly work to find appropriate placement for elderly clients as well as providing early intervention to prevent the need for hospitalization.

2. Proposed Program

The following outlines the minimal proposed program which is designed to help maintain the older adult at a maximum level of functioning in the least restrictive setting. Crucial to this program are the linkages and coordination with other portions of the mental health system and the training of mental health staff to the special needs of the elderly. Target groups:

a. Persons over 60 who are at risk of hospitalization or placement out of their home because of impaired functioning or disturbed behavior.
b. Persons over 60 who are at risk of being placed into a more restrictive environment because of impaired functioning and/or disturbed behavior, i.e., a person being moved from a general skilled nursing facility to a locked facility nursing facility.

1. C.M.H., Review, Volume 2, No 3, 1977, p. 3
2. House Select Committee on Aging, letter dated February, 1979.
3. Resnick and Kantor, American Geriatric Society, 1978.
4. Services Assessment Summary Report based on July 1, 1977, through June 30, 1978, discharges.

Secondary to the primary goal as stated above are the following:

- Prevention and early intervention for identified patients who might other wise require acute hospitalization or placement in a more restrictive environment.
- Prevention of the onset of psychiatric symptoms in the well elderly population.
- Specialized components for the particular needs of minority elderly.
- Emphasis on education (community, staff, etc.) and early intervention.
- Inter-agency coordination (i.e. Public Health, Social Services, Drug Abuse, etc.) in the development of specialized programs to the elderly.

It is suggested that the most effective and efficient means for attaining the above goals is the development of mobile outreach teams in each Region. Priority services will be:

- Home and Protective setting assessment, treatment, and follow-up.
- Case management of elderly clients and consultation/education to the staff of:
  - Acute 24-hour services
  - Skilled nursing facilities
  - Community care facilities
  - Other community-based mental health programs, i.e., outpatient services.

In addition to these specially trained mobile outreach teams, the following components are essential to provide a comprehensive, full range of services to the elderly.

- Psychogeriatric skilled nursing facility
  The need for this type of specialized skilled nursing facility for mentally disturbed elderly persons has become critical. General skilled nursing facilities are increasingly reluctant to accept or maintain elderly persons with behavioral or psychiatric problems. Often these patients are kept inappropriately in an acute 24-hour facility because no more appropriate, less restrictive placement can be found. Alameda County Mental Health Service has developed a request for proposal for this facility and is awaiting the allocation of funds necessary for implementation.

- Day Treatment
  This service provides day time care for those clients who can live at home, but are in need of some daytime psychiatric treatment. Often, without a program of this type, the

elderly client again requires care in a more restrictive setting.

- Halfway House(s)
  This facility is useful for persons who require an active stabilization program in order to progress to more independent living or a residential care facilities.

IV. SUMMARY OF RECOMMENDATIONS FOR ADULT CONTINUING CARE (Not prioritized)

A. Alameda County must implement the plans for a L-facility in order to provide care at a local level.

B. The development of community psychosocial resources and local alternatives to hospital-based care is imperative.

C. The role, responsibilities, and activities of the Patients' Rights Office needs to be examined and expanded to provide for the protection of rights for all clients.

D. Procedures and policies relative to the administration and monitoring of psychotropic medications need to be developed and implemented.

E. Relatives and friends of clients need to be involved, when appropriate, in treatment planning, aftercare planning, and in educational programs regarding the illness, medications, prognosis, etc.

AD HOC PLAN COMMITTEE'S ADDITIONAL COMMENTS:

It is suggested that the Mental Health Advisory Board establish an ongoing Adult Services Committee to work with the agency on:

- Alternatives to hospitalization.
- Improvement of protection of patients' rights.
- Development of a model for Patients' Rights advocacy, exploring options, and defining advocacy role of all staff members.
- Special Patients' Rights issues of ethnic and sexual minority populations, persons with disabilities, and other special target populations.

ETHNIC MINORITY CONCERNS

I. INTRODUCTION AND BACKGROUND

The Ethnic Minority Concerns Committee was established as a standing committee of the Mental Health Advisory Board over a year and half ago to assist the Agency in developing improved ethnically and culturally appropriate services for the large number of minority persons in Alameda County. Membership on this committee has included representatives of most of the ethnic groups within Alameda County and persons from county-operated and contract mental health programs, other minority programs, the Mental Health Advisory Board, and the community. This year, despite a lack of sustained, consistent committee membership, no available evaluation staff, and the enormity of the tasks, three major areas were addressed:

A. Analysis of the current mental health services to ethnic minorities, in relation to the needs identified in the 1977-79 Needs Assessment. Areas to be examined included "acceptability, accessibility, availability, cost, quality, and continuity," as required by the 9/20/78 State guidelines.

B. Data collection, and,

C. Affirmative action.

Although these two areas of evaluation taken as tasks by the committee do not directly relate to the needs assessment of the cycle's first year, they are now mandated by the State and included by the committee in this year's planning process because of the committee's concerns about their current status and relevance to the ability to properly evaluate and modify services now and in the future.

II. TASKS AND RESULTS

A. EVALUATION OF SERVICES TO ETHNIC MINORITIES

Evaluation of all County services is an extremely complex task requiring a continuous effort by people trained and skilled in the appropriate techniques and methods. The evaluation of services in a systematic and scientific manner is beyond the scope of a group of volunteer citizens and staff unfamiliar and untrained in such matters and was felt to be difficult, if not impossible to achieve from the start. An attempt was nevertheless made to gain an overview of current services to ethnic minorities, particularly from the standpoint of accessibility and availability. This took the form of a questionnaire to the two Regional Program Chiefs. They were selected as the two people with the broadest current overall perspective of mental health services to ethnic minorities, and the authority to implement changes if needed.

The design of the questionnaire was influenced in part by several questions proposed in last year's Plan, as well as by the theme of accessibility reported in prior subcommittees and in the State's Policy and Intent Statement.

The following was the major question asked:

- Are presently available County and contracted mental health services accessible to ethnic minorities?

This question was then further defined in terms of cultural, linguistic, geographic, and temporal accessibility, modalities, and types of treatment available and the presence of special programs. Each of these categories was questioned as follows:

1. Cultural Accessibility

   a. To what extent are the environmental appearances of your unit reflective of the large ethnic minority cultures (values, mores, interests) in your Region?

   b. Is any person or group of staff active in in-services education and consultation regarding cultural issues? If so, please describe.

   c. How are cultural factors considered in caseload assignments?

   d. What is your bicultural clerical and clinical staff ratio to non-bicultural staff? Include position and ethnicity.

   e. What proportion of minority clients are being seen by ethnically matched clinicians?

   f. What formalized working arrangements do you have with other agencies serving minority populations (e.g. social services, health services, mental health services)?

2. Linguistic Accessibility

   a. What is your clinical and clerical staff ratio (bilingual or English)?

   b. Give staffing breakdown by position, language, and culture.

   c. What is procedure for bilingual and monolingual case assignment?

3. Geographic and Temporal Accessibility

   a. Location of services and convenience of availability to public and private transportation (parking, buses, BART).

b. Hours of operation?

c. Do your services have drop-in capability?

4. Mode of Service

a. What other modalities of treatment are used in your services besides the traditional modes?

5. Types of Services

a. What is the range of services offered to your ethnic population (e.g., partial hospitalization, outpatient, emergency, CE & I)?

6. Special Programs

a. Describe any special programs available to your minority population.

Preceding all of these categories was one of demography which asked the following questions:

1. What are the predominant minority groups in your region?
2. What percent of the general regional population do they constitute?
3. What percent of your current active regional caseload includes these minorities?

Analysis and interpretation of the data proved, unfortunately, to be difficult if not impossible. Some reasons for the difficulty are:

1. Lack of uniformity in recording, storing, and ability to retrieve information.
2. Variation in the response format from service site.
3. Lack of inclusion of most large and small contracts in the questionnaire responses.
4. Even though these difficulties existed, the information available can be presented and analyzed to help us gain some appreciation for the problems that exist and to give some direction to future evaluation processes.

The following observations may be made of the information collected:

1. Data suggests that needs for services require more sophisticated, weighed criteria than simply the proportion of the general population. For instance, although one ethnic group may be receiving services in an amount greater than its size in the community would seem to indicate, it may in fact be much more needy at a particular point in time (recent arrivals from Southeast Asia). Other populations may constitute a very small ethnic minority, yet may have major mental health needs (American Indians).

There is also inconsistency as to what comprises an ethnic group category, such as Asian. Sometimes, the Pilipino population is included, and other times, not. There are also substantial cultural and language variations within the broad "Asian" category and these must be more specifically identified.

2. In many instances, there is good correlation of bicultural staffing to that ethnic group's representation in the general population. At other times, the information is lacking because of variations in recording and reporting. Some groups are underrepresented when considering only the County-operated services, but may be better accounted for if the special ethnic contract programs had been included.

   Linguistic accessibility, particularly among first-line personnel appears to be limited or absent, at several reporting sites. Furthermore, findings indicated that a more flexible use of bilingual-bicultural staff might be explored to better utilize existing ethnic minority personnel.

3. All services are accessible by public transportation, although the appropriateness of the location or the time required to reach a service site was not commented on, but has been an issue at several service sites. Services located in large shopping complexes may be difficult to locate without adequate outside signs and several South Region services remain on Fairmont Hospital's institutional environments, despite efforts to the contrary by the Mental Health Administration.

4. The majority of reporting sites provide primarily traditional modes of therapy. It is not possible to compare this with any special ethnic contract programs since these were not included in the questionnaire responses.

5. The general range of outpatient, inpatient, partial hospitalization, partial day, and CE & I services are available, although they may not be accessible because of linguistic, cultural, geographic, or temporal reasons.

B. DATA COLLECTION

The State Department of Mental Health "Policy and Intent Statement Regarding Mental Health Services to Minorities" states that "each county shall utilize in the county plan information provided by the Department of Mental Health in the county population by race, ethnic group, sex, age, physical and mental disability, income, and primary language in which each person is fluent." It further requires that "each county shall provide data in the plan regarding county or contract mental health staff by race, ethnic group, sex, program, employment position, and region employed," and that "the bilingual/bicultural capabilities of staff shall also be reported."

While agreeing with the concept and intent of this statement, the Committee feels that information provided to and from the State and County is too general and of limited value to actual program sites. The Committee recommended that the collection and utilization of ethnic minority data be on a yearly basis as an essential part of an ongoing assessment process and that the information needs to be included in the more discrete service site descriptions. This would then provide significant data in a more useable, relevant form to the local programs and the communities they serve.

To this end, a method has been devised whereby minority data is collected and presented by the individual service sites. Such information is included in the already existing Form E's which each service unit is required to complete annually for the Plan. In this way, the State's reporting requirements are met in a format most relevant to a particular service for use in the ongoing evaluation and planning of its program and staffing design.

C. AFFIRMATIVE ACTION PLAN

Due to lack of time and the document not being available, the Committee was not able to complete its evaluation of Mental Health's Affirmative Action Plan.

III. RECOMMENDATIONS (NOT PRIORITIZED)

In reaffirming the commitment to consistent movement toward a staff and service system responsive to the social-cultural mental health needs of communities served, the following recommendations are made, based on the work of the Ethnic Minority Concerns Committee and the Mental Health Agency:

A. There is the need for staff trained and skilled in evaluation methods to be closely assisted by an ongoing, active committee of citizens and County personnel. Assessment then becomes a year around process with the ability to evaluate and recommend at any point in time, particularly when the changes desired are actually possible to implement.

B. A standard format must be developed to enable the storing and retrieving of data so that administrative and organizational differences do not interfere with its collection. The new billing and data system now being implemented should address this need.

C. A mechanism must be developed for the collection, reporting, and utilization of data from contracted programs within the Short-Doyle system.

D. A standard set of criteria for determining mental health needs and whether or not those needs are being met must be developed before

attempting further evaluations. This year's process suggests that criteria besides a particular ethnic group's size in relation to general population must be considered. Factors such as degree of isolation, recent immigration, language, etc., should be included and weighed.

E. Though the category of "Asian" may be useful, the differences in culture and language among Asians should be further delineated.

F. This year's data suggests the possibility that ethnic minority staff assigned to some service sites may be better utilized if either their work assignments were elsewhere, or shared between two units. This poses biostatistical recording problems, territorial issues, and the rights of an individual to be employed where he/she desires. It is a difficult, but important issue that needs investigation, resolution, and implementation through a County-wide policy.

G. County-operated programs, with the exception of the Asian Program, offer primarily traditional modalities of treatment. It is not clear at this point whether contractors offer any non-traditional, culturally related modalities either, or whether such is even necessary or desirable. It is an area which has not been given much attention in the past, and might be considered for a needs assessment in the future.

H. Ethnic minority in-service training has been occurring, but it is not clear for which minorities, to what extent, covering what issues, and who is attending. It is recommended that a system of documentation of these events be developed and regularly reviewed for their appropriateness and value.

I. Formalized working agreements should be developed between County-operated and ethnic-specific contract services to ensure that the sensitivity and availability of services is addressed.

J. The Mental Health Affirmative Action Plan will require evaluation once it becomes available, and it is recommended that a subcommittee be formed to pursue this. A related matter involves the status and workability of the bicultural classification concept recently approved by the County.

K. The redesign of the Form E's is a significant step in the direction of more relevant and useful ethnic minority data collection. This yearly documentation will help provide a truer picture of the level of services to ethnic minorities over time. At the completion of this Plan, the form and data should be carefully evaluated to maximize the utility in future plans.

L. In addition to the above recommendations, Mental Health Administration recommends and is developing a workshop to explore the advantages and

disadvantages of ethnic-specific versus integrated services. This is a complex issue, and the results of the workshop should assist in the design of services sensitive to the unique mental health needs of ethnic minority groups.

PERSONS WITH DISABILITIES

I. INTRODUCTION AND BACKGROUND

As pointed out in the plan report from this committee last year, the overall prevalence of persons with disabilities in Alameda County probably approaches 20%.

> "Persons with disabilities and their families are at significantly greater risk of mental and emotional malfunction than the population at large. The greater difficulties experienced in simple day-to-day coping reduces the reserve available for dealing with the unusual or urgent. Crisis is frequently overwhelming and produces a greater potential for breakdown."
>
> (Short-Doyle Plan, 1978-79)

This year the committee, composed of many of the same persons representing specialized and appropriate programs, i.e., Mental Health Advisory Board, Center for Independent Living, Deaf Counseling Advocacy and Referral Agency, Mental Health staff, etc., began the work of implementing some of the recommendations made last year, most of which had not been acted upon.

Last year's work indicated several areas of concern relating to availability and accessibility of mental health services that Alameda County provides directly or contracts with others to provide. Several discrete issues were decided upon. Various committee members selected areas on which they wished to focus, developed these areas into tasks and worked on the tasks using staff persons as resources. The committee members used the regular meetings to bring each other up to date on the progress of their tasks, share new information, and institute any change of direction that seemed appropriate.

II. TASKS AND APPROACH

A. Review of the Alameda County Mental Health Service Agreement with the Regional Center of the East Bay and Current Level of Implementation.

An informal telephone survey of providers and consumers last year indicated that the mental health care of persons with development disabilities was an area of concern. The agreement between the Regional Center of the East Bay and Alameda County Mental Health Services that outlined agreed upon divisions of responsibility was reviewed. Additionally, the indicated agencies and persons were contacted to find the current level of implementation of the agreement.

B. Review of Contracts for Mental Health Services.

Last year's work raised questions concerning accessibility of ser-

vices contracted for by Alameda County. Review and evaluation of services and contracts concerning accessibility and availability was indicated. The contract formats and the present contract monitoring mechanism were reviewed this year.

C. 504 Self-Evaluation Checklist.

A questionnaire was distributed to all county and contract programs last year. The return rate was poor and minimal information could be gathered from the data. The committee decided to request the Program Chiefs to be responsible for distribution and return this year of a self-evaluation form to be used by the County Administrator's Office and developed by HEW to monitor compliance with Section 504 of the 1973 Rehabilitation Act.

D. Biostatistical Data on Utilization of Services.

Last year's work indicated there was no statistical data available about utilization of services by persons with disabilities. This year the committee wished to specifically work toward the development of an ongoing process to gather this data and to work with the appropriate units within Alameda County Mental Health Services to develop this biostatistical data base.

E. Mental Health Needs of the Deaf.

The specific needs of deaf persons were not explored last year due to time constraints. These needs were pursued this year and the area of emergency and inpatient care was selected as one of the most critical areas in the mental health care of the deaf.

III. RESULTS

A. Services to the Mentally Disabled, Developmentally Disabled Population.

The written agreement between the Regional Center of the East Bay and Alameda County Mental Health Services (see Section V of this plan) seems to be specific and inclusive enough to delineate responsibility. At the time of initial review, specific persons had not been designated. However, during the course of the review of the agreement, the psychiatric inpatient service at Highland Hospital has designated a specific team to deal with the inpatient care of developmentally disabled individuals. Simultaneously a series of meetings was scheduled between appropriate people in the Alameda County Mental Health Services and person from the Regional Center of the East Bay. Orientation meetings were held for exchange of information and the designation of specific persons for liaison in designated areas has begun. The completion of this work was felt to adequately develop the mechanisms to provide services

that were of concern last year.

B. Contract Review.

Review of the contract format used by Alameda County Mental Health Services indicates several pertinent sections regarding services to persons with disabilities. This format obligates the contractor to provide all services without discrimination regarding physical handicap, and states that handicapping condition of any sort will not be the reason for exclusion from participation in or denial of the benefits of the program. The contractor agrees that he or she shall not provide any service or benefit which is different, or provided in a different form, because of any handicapping condition and specifies that service to persons with a handicapping condition shall not be segregated or provided in a separate form, and specifies that any handicapped individual shall not be treated any differently from any othre person in determining criteria for admission, enrollment, eligibility, membership, etc. The contract also obligates the County to assign a liaison to the contractor with respect to the performance of the contract, stating that the County will make at least one program evaluation during the term of the contract. Also, if for any reason the contractor does not fulfill the contract or violates any of the agreements, the County has the right to terminate the contract.

It appeared to the committee that the format of the contract was entirely satisfactory. However, it appeared that both the County and the contractors were negligent in fulfilling the specifications of the contract.

C. 504 Self-Evaluation.

The tabulation of the results of the survey, including the names of the responding service sites, along with the questionnaire that was used, are available upon request.

A summary of the results reveals:

1. Although there was not a 100% return, this year's return rate of 82% (88% contract programs, 76% county operated programs) was significantly better than the previous year's return rate of 27%. In addition to the brief questionnaire, the self-evaluation checklist contains nine pages of written descriptions, definitions, and examples that are an effective introduction to the regulations pertaining to "504". It had been hoped that reviewing this material would be beneficial to service chiefs in augmenting their knowledge and in completing the questionnaire.

2. In spite of the nine explanatory pages appended to the checklist, a significant number of respondents did not seem to have a clear understanding of the checklist itself. The respondents added

comments or raised questions on the checklist that would have been explained by a careful reading of the introduction.

For these reasons, the committee concluded that distribution of written information concerning persons with disability and/or the regulations pertaining to services for persons with disability is not an effective way to increase awareness by itself.

3. Several of the contractors wrote comments that they were concerned about providing services to persons with disabilities, but present staff, present physical structure, etc., did not allow them to do so. The implication was that with additional county funding they would be willing to purchase auxiliary services, increase staff, renovate structures, as might be required.

   Previous review of the contract format indicates that the contractors have agreed to provide all these services, and that the contracts could be voided if they did not. It is also explicit in the contracts that there would be no extra funding available for these required services.

D. Biostatistical Data.

Review of the plans of the Revenue and Data Control Services for implementation of the MH/AD Billing System indiciated that there is potential for gathering biostatistical data regarding disability of clients served. While these possibilities were being explored, the State directed the Mental Health Services to provide this sort of data, and specified a 60 item scale. This will be implemented Phase Two, by July, 1980, of the MH/AD System.

Informal discussion with the Mental Health Services Evaluation Unit indicated that it might be possible to use the Services Assessment Summary, or other instrument, in the intervening year to begin gathering data, and to implement any temporary system that appeared feasible.

E. Services for the Deaf.

A meeting was held between representatives of the Psychiatric Inpatient Service/Psychiatric Emergency Service at Highland Hospital and representatives of Deaf Counseling Advocacy and Referral Agency (DCARA) in order to orient the respective staff persons to services provided by their programs. As a result of this meeting, DCARA has agreed to provide one or more workshops to aid Highland Services staff to more effectively deal with hearing impaired patients. The psychiatric services at Highland agreed to explore (and implement as possible) a uniform method of obtaining and

paying for deaf interpreters from DCARA with the intent that this method could be used on a countywide basis.

DCARA will subsequently initiate a client satisfaction survey to take place between April and November, 1979. This will deal with the experience of hearing impaired persons on the Inpatient and Emergency Services. Should any recurring deficiencies appear, DCARA will work with the 24-hour services to remedy them.

DCARA will provide a pre-workshop evaluation to obtain a baseline of the quantity and quality of resources utilized in working with hearing impaired clients on the Emergency and Inpatient Services and will conduct a subsequent post-workshop evaluation to delineate changes.

IV. RECOMMENDATIONS (not prioritized)

The committee recommends that the current contract format be continued, with all features of the contract being complied with by both parties. The recent designation of a staff person responsible for contract monitoring should help implement this recommendation. Additionally, contractors should be informed that fulfillment of a contract requires removal of architectural barriers, furnishing of sign interpreters, provision of recorded and/or Braille materials, etc., without additional funding.

The committee concludes that neither the appropriate county persons nor the contractors are adequately aware of the ramifications of the contracts. This should be made clear at the time of signing the contract. The contracting agency should be made aware of its responsibilities and of the expectations of the county regarding those responsibilities. Further, regular monitoring of the contracts should review these functions.

In order to better achieve understanding of the 504 regulations and responsibilities, the committee recommends that Mental Health Services hold informative and educational workshops (with required attendance) concerning Section 504. This should be coordinated through the Affirmative Action Officer's Office of the County Administrator's Office and should include all Chiefs of Service and above in the Mental Health Services and all corresponding persons in contracting agencies.

Mental Health Services should develop a long-term plan to increase the knowledge and skills of mental health staff regarding the life experience of persons with disabilities in order to enhance and augment the ability to deliver appropriate mental health services to this population. The plan should be in writing, should include explicit objectives to be achieved, and should have a timetable.

The necessary consultation, education and information services should be obtained by contracting with existing community agencies such as

Center for Independent Living, Berkeley Deaf Counseling Advocacy and Referral Agency, Catholic Charities, et al.

In view of the fact that two self-surveys have not been successful in getting a true total picture of accessibility of services and facilities for persons with disabilities, a long-term plan should be prepared, with explicit objectives and timetable, to produce an accurate survey with specific written plans for remedying any problems discovered. Existing community agencies specializing in such assessments should be utilized. (Such services are currently available at minimal or no cost.)

PRIMARY PREVENTION

INTRODUCTION AND BACKGROUND

This report examines the public health model for primary prevention services. Prepared by a task force representing the Mental Health Advisory Board, citizens, providers and Mental Health Staff, it examines for the first time in the S/D Plan, the provision of services designed to promote mental health. Focusing on primary prevention does not imply, of course, that other levels and models of prevention are not currently present in the Mental Health system or that these do not need to be improved and enhanced. Future efforts might certainly explore secondary and tertiary prevention services that work to limit the impact of existing mental and emotional illness on people.

The report suggests that "prevention," while cited as a priority at both the County and State levels, is in fact inadequately implemented with respect to allocation of resources both fiscal and professional. The study discloses, further, that whereas this has been true throughout the mental health field since the passage of the National Mental Health Act in 1964, there is, at the present time, an accelerating interest in preventive mental health concepts and programs.

At the federal level, NIMH is offering substantial incentives for programs aimed at preventing mental illness such as life cycle prevention programs relating to stresses normally experienced during different phases of living, positive mental health programs among children and adolescents, and stress management programs to reach high-risk populations before mental health breakdowns occur.

There is both a new awareness of special needs and an awakening professional interest in developing models of preventive intervention. In Alameda County, an entire postgraduate program at the University of California at Berkeley is redesigning its curriculum exclusively for the preparation of mental health specialists in Primary Prevention.

IDENTIFIED NEEDS

The review of these trends and of the Alameda County programs having prevention components underlines convincingly the congruence of new forms of public mental health programs with newly emerging appeals for help with "coping" among community constituencies. The Task Force has identified an urgency for mental health outreach to temper the stresses leading to breakdown among the populations most at risk from the circumstances of contemporary urban living. Alameda County has a high proportion of such citizens; ethnic communities, life-style minorities, the poor, the unemployed and dislocated, to name a few. These underserved and overstressed communities ask for and describe the kinds of mental health interventions which will help them cope with societal stress before it leads to breakdown. The need is for new forms of

outreach, and new kinds of training, designed to meet the particular needs of those communities most affected by stress. The need is also for relevent service models which are possible when the talents and knowledge of practitioners, consumers, and citizens are synthesized. The Task Force has identified programs which exemplify such models among existing services. These services appear to be more appropriate for primary prevention among the high-risk populations described, than the traditional Consultation, Education, and Information programs or classical "case consultation." They may also be substantially less costly per capita.

TASK FORCE STRATEGY AND INFORMATION COLLECTION

Since there had been no specific past effort to isolate Prevention as an aspect of the County Plan, the Task Force followed the strategy of first defining and then pursuing its own mandate as follows:

A. The concept of "prevention" in mental health is defined in many ways. The Task Force met for several sessions to evolve a working definition it could agree was most appropriate for the context of Alameda County's needs and services.

   The group read and discussed both pertinent mental health literature and Alameda County C E & I contracts, arriving easily by consensus at a definition and focus of primary prevention which can be generally paraphrased as follows:

   > "Primary prevention encompasses those activities directed to specifically identified vulnerable high-risk groups within the community who have not been labelled as psychiatrically ill and for whom measures can be undertaken to avoid the onset of emotional disturbance and/or to enhance their level of positive mental health. Programs for the promotion of mental health are primarily educational rather than clinical in conception and operation with their ultimate goal being to increase people's capacities for dealing with crises and for taking steps to improve their own lives."
>
> (Stephen E. Goldston - NIMH-NAMH Report, 1976

B. Personal interviews and evaluations of several programs were conducted. These programs were chosen by reading the C E & I components of all county contracts and selecting those which contained the best-developed ideas for primary preventive programming. Following individual interviews, the Task Force met to discuss its findings, and then chose one program to describe in detail because it well exemplifies a model for primary preventive intervention with an identified population at risk.

C. As the appropriate yardstick for evaluating primary preventive aspects of programs reviewed, the group used as reference the public

health model of mental health, which is increasingly becoming the intervention of choice in the field of primary preventive mental health. Its characteristics are described below, although, of course not every program meets every criterion.

1. Practice is in the community rather than in an institution.
2. Emphasis is on total community as the defined population.
3. Emphasis is on preventive services.
4. The program meets the spectrum of mental health related needs in the community.
5. Emphasis is on indirect services - e.g., consultation, education to the people working with primary caretakers in contact with larger social systems schools, teachers, public health nurses, etc.
6. Emphasis is on innovative strategies.
7. There is a rational planning process in decision-making, demographic analysis with respect to unmet mental health needs and identification of populations at risk.
8. There is evidence of new uses of new sources of manpower, paraprofessionals, community mental health workers.
9. There must be commitment to community involvement.
10. The program engages in identifying sources of stress within the community.

(Bernard Bloom, NIMH, 1967, pages 49 - 51)

Committee members in reviewing contracts and interviewing, kept in mind the following questions:

- Whether programs were pursuing the interventions they themselves had conceptualized in their C E & I contracts.
- The nature of their success and/or failure with primary preventive programs.
- What more might they have done, given greater resources.

INFORMATION ANALYSIS

Of the programs reviewed, the CASA (Cambios por Accion Social para Avanzar) Program below was selected as the program best fitting the public health model of primary prevention for the following reasons:

1. It serves a population with known high-risk characteristics.
2. Its program has been developed from a sophisticated professional conceptual base.
3. Its implementation of primary preventive programming has been consistently guided by a top priority for protected time and staff resources.
4. Its program design has been directly related to community mental health needs identified through documented research.
5. Its programs are delivered by community helath workers carefully chosen and professionally trained for their understanding

of and identification with the population served.

6. It is a part of a comprehensive program -- La Clinica de la Raza of Fruitvale Health Project, Inc. -- a community clinic, which was developed and implemented by community people and students from local colleges and universities. La Clinica's other mental health component is El Centro de Salud Mental.

DESCRIPTION OF THE MODEL

The Task Force study of the model began with the description of needs and services defined in the initial C E & I contract as follows:

"Need For Program:

"Over 50,000 Raza and even a wider range of minority people live in Northern Alameda County area. This population is victim to a myriad of social problems; poverty, unemployment, low educational attainment level, alcoholism, drug abuse, cultural conflicts, and institutional racism. In spite of the presence of these social ills affecting in particular the Raza community's general mental health, the Health Care Agency was not providing appropriate mental health services to this population. El Centro de Salud Mental was initially contracted in 1973 to respond to this gap within Alameda County's Mental Health Service system. Through El Centro's and other community programs that now provide culturally and language-sensitive mental health services to the community, the Alameda County Mental Health system has moved closer to being more fully responsive to all communities within its boundaries. The continual increase of El Centro de Salud Mental's client caseload during the course of the past five years provides adequate evidence of the ongoing need for specialized out-patient mental health services to Alameda County's Spanish-speaking population.

"El Centro de Salud Mental specializes in providing bilingual/bicultural Spanish out-patient mental health services to Northern Alameda County's Spanish-speaking population in most need of such services. This is done through continual development of educational and innovative approaches which will be most sensitive to addressing community mental health needs and most effective in resolving presenting mental health problems. Compounding the problem of unavailability of mental health services to particularly the Raza population, was the community's perception of existing public mental health services. Raza and other minorities rarely seek public counseling centers as a definite source of assistance in time of crisis because the existing counseling programs have historically never been a reliable source of aid.

"The C E & I program will continue to address the lack of understanding by the Raza community and other minority programs as to the nature and availability of mental health services; the lack of primary prevention services promoting positive mental health and counteraction of harmful forces before they have a chance to produce mental crisis or illness; and the lack of understanding

of community mental health by the Raza 'gatekeepers' who are in touch with the Spanish-speaking community.

"Purpose of Program

1. To provide education/outreach services for Catchment Area #17, 18, 19, and 20 residents.
2. To provide mental and human resources assistance to Raza community members in need of such services, in addition, provide mental health education intended to facilitate their understanding of social and interpersonal problems affecting their mental health.
3. El Centro will continue to provide "policy impact" education, consultation, information, and community organization services to the Health Care Services Agency, mental health service programs and other human services providers or organizations affecting mental health.
4. To administer a preventive mental health service for children and youth which is operated on volunteer and foundation funds. This service is intended to promote positive mental health among children and youth through educational workshops. Services will be provided to schools throughout the Catchment Area #17, 18, 19, and 20.
5. El Centro de Salud Mental will continue to provide specialized mental helath consultation, education, and information services to significant Raza 'gatekeepers' and non-client individuals so that they can recognize the mental health dimensions of their work with their clients,and through this awareness, expand their potential for the prevention of emotional mental disorder and the promotion of positive mental health.
6. Service Coordinator and appropriate staff will participate in administrative and/or planning meetings with East Oakland Mental Health Services, in order to assure optimal coordination of mental health services to residents of Catchment Area #17, 18, 19, and 20.

"Services Provided

Consultation: To provide technical assistance by direct contact - sharing skills, knowledge, and training with allied professionals or community care givers to increase the latter's understanding of human behavior and to improve their relationship with the client. The primary goals are problem-solving, increasing mental health skills, and improving the capability of the allied care givers or their agencies.

Education: To provide knowledge of the principles of sound personal and community mental health through direct contact with agencies, community groups and individuals not identified as clients.

Information: To provide information by directly contacting agencies,

community groups and individuals not identified as clients. Information is about mental health services, including location, types of services, referral channels, changes in programs, and significant legislation. Also included are indirect contact with the general public through literature and the mass media regarding mental health and mental disorders.

Community Organizations: Involvement in community organization projects to enhance the planning and development of programs which have broad impact upon the community.

Community Client Advocacy: Provide person to person mental health services for assisting in obtaining responsive, competent, and effective care."

A comprehensive interview with the coordinator of CASA revealed that the services described above are implemented and reflect a refreshing vitality as well as a well-developed and very popular program of primary prevention activities. All eight community workers (paraprofessionals) are bilingual/bicultural men and women specially trained by bilingual/bicultural mental health professionals. The program is multifaceted, and includes:

- Regular mental health classes in public schools.
- Workshop on Sexuality, Communications, Family Relations, and Assertiveness (the thematic areas were chosen after careful survey of most common problem areas identified among the populations to be served).
- Consultations with school counselors and teachers.
- Evening groups for parents.
- Information sessions with community agencies and groups.
- Individual problem-solving and advocacy consultations with clients seeking help with negotiating stressful problems around social security, social welfare, legal issues, etc. The majority of clients are unemployed and/or welfare recipients.

The CASA program has been developed in direct response to a community needs assessment based on a study of caseloads at El Centro de Salud Mental in 1976. An analysis indicating the presenting problems and their causation provided guidelines for what needed to be done in primary prevention programming. The C E & I contract for CASA described the rationale and anticipated program design.

The Task Force interviewer found that current CASA services accurately reflect its program goals.

Response to these services has been high, and programs are obviously popular as indicated in records of attendance. There would be work for twice as many staff, but the program doesn't

wish to grow too fast beyond its current potential span of responsible administrative and supervisory control.

Program examples: At Hamilton Junior High School, the program runs two groups of at least 30 students every week for the full school term. Attendance is high. At Oakland Tech, the program has been running successful groups for three years. In some schools, the students sign up voluntarily; in others, the courses are required and given for credit. At the Oakland Street Academy for high school dropouts (predominately Black and Chicano), attendance is consistently high, in contrast to other classes there.

The program has created its own course materials through modifying professionally prepared texts to suit the local situations and test-running them with their own indigenous staff. The subject areas have been chosen to correlate directly with the problem areas indicated in a survey of patients at El Centro. Courses are actual group exercises in coping skills with discussion around common problems. Evaluation by staff of every class session is careful and thorough, as are all program activities, with a serious eye toward improving staff knowledge and performance. CASA has a system of self-evaluation beyond the current requirements for service unit reporting to ACMHS. It is evident from the coordinator's own performance and from the atmosphere which prevails at CASA that staff are highly motivated feeling the effectiveness and response to their work.

TASK FORCE ANALYSIS RESULTS

The Task Force survey produced the following analysis:

A. Primary prevention program services appear to be effective and heavily used under certain conditions:

   1. When designed in response to known community needs among a population at risk.
   2. When there is a carefully designed program which consciously translates known preventive mental health principles.
   3. Where mental health funds are specified for staff trained for preventive interventions.
   4. Where there is protected time assigned for it.

B. Development of evaluation capability due to staff loss had been delayed following Proposition 13 cuts and needs to be promptly and vigourously pushed.

C. Mental health professionals interviewed are united in their concern that more should be done in primary prevention, but that the important priority on services to the severely mentally ill limits attention to primary preventive services.

D. In times of revenue reduction such as the present, the services

most seriously affected and the first likely to go, are those related to primary preventive programming.

RECOMMENDATIONS

1. The evidence of the survey suggests that, without specifically protected attention to primary prevention, resources inevitably erode because of the heavy emphasis upon services to the chronically mentally ill. This is happening is spite of federal, state, and local recognition that a primary preventive component should be an identifiable part of the mental health services spectrum. It might be proposed, as a corrective feature, that a proportion of every mental health dollar be reserved for primary prevention.

2. This recommendation acknowledges both the necessity for protected priority for primary preventive services and the increasing timeliness for primary prevention as a response to emergent needs and opportunities.

3. The Task Force believes that both research and experimentation in primary preventive mental health provide models and methodological background out of which programs can now be confidently developed.

4. The Task Force studies also convince us that there are specific populations at risk in Alameda County for whom preventive services might well reduce future demands for clinical interventions among those identified populations. These include: The unemployed and underemployed, ethnic minorities, displaced persons, populations at risk due to life crises, the elderly, children of single parents, children and adults subject to sexual abuse and suicidal persons.

5. The Task Force recommends that a program of primary prevention based on a public health model such as that described in this report, be conceptualized and implemented among designated populations at risk in Alameda County as a priority among planned mental health services for 1979-80. This should be seen as a first step toward a continuing commitment to primary preventive programming. Toward this end, the Task Force specifically suggests that the Director of Mental Health Services assign staff time for follow-up on the beginning work of the Task Force to assess both the effectiveness of existing programs and the level of need to which Mental Health Services should be responding with primary preventive interventions. This will require, of course, a preliminary demographic study of populations most seriously at risk and an aggressive commitment to experimenting with new models of primary preventive intervention.

SUMMARY OF AD HOC GROUP
AS DESCRIBED IN PLANNING PROCESS

Consistent with the planning process and following the completion of the Plan committee reports, representatives of the Alameda County Mental Health Services and the Mental Health Advisory Board convened an Ad Hoc group, reviewing the content and recommendations contained in the reports and making additional comments and recommendations, many of which have been incorporated into the individual reports. A number of other overall system-wide issues raised for discussion by the group are listed below. These items are not prioritized and are all seen as crucial to the ongoing development of a comprehensive mental health system of services accessible and sensitive to the mental health needs of Alameda County residents.

1. Recognizing that the development of a comprehensive mental health system requires constant assessment of need, implementation of programs and evaluation, the crucial issue facing local programs is the allocation of resources. There continue to exist many unmet needs among the priority adult and children populations who have a history or are in danger of psychiatric hospitalization.

   There are, additionally, the special concerns of particular underserved populations such as ethnic and sexual minorities, children, the elderly, the persons with disabilities, etc. The group suggests that limited resources, whether fiscal or human, need not be the only determinant of the system's ability to respond to those needs. Alternative structuring of the system of services, or redirecting resources must be explored creatively and thoughtfully with a maximum of citizen, consumer, and professional input.

   Along with this, expanded resources must be developed in order to meet the ever-increasing demands on the system. As new needs arise, programs to address those needs must be developed through a reallocation of existing resources in addition to receiving new resources.

   Additionally, greater emphasis and effort must be directed toward cooperative, interagency approaches to human service needs to minimize territoriality and maximize quality of care.

2. An area of particular interest has been the inclusion of the consumer perspective in the design and implementation of services. Significant progress has been made during the past few years. Several client feedback surveys have been conducted. Consumers of services have begun to participate in the planning process. Plans are being made for a comprehensive client feedback survey to be conducted by the Planning Office. The Ad Hoc Group supports these efforts and encourages the continuing commitment to the soliciting of client/consumer participation.

3. There is much work being done throughout the system to ensure the quality of the services provided. In addition to the system-wide and program

planning, many quality assurance mechanisms have been or are being developed for county-operated and contracted services. Among these are:

- Case recording policies
- Medication practices, standards and monitoring
- Workload standards
- Staffing pattern analysis and standards
- Peer review
- Supervisory standards
- Task-oriented job descriptions and evaluations
- Improved management data capabilities
- Clinical and administrative staff training
- Evaluation studies

Quality of care issues are of concern at the local, state, and national levels and resources must be maintained to ensure the quality of services.

4. Most crucial to the "reality" of any plan is the accountability and responsibility for concerted follow-up on recommendations resulting from the planning process. The Ad Hoc Group suggests that clear, well-documented responses and action plans be developed by Mental Health Administration delineating steps that can be taken in response to the recommendations in the 1979-80 Short-Doyle Plan.

MENTAL HEALTH NEEDS ASSESSMENT

OF

THE SEXUAL MINORITY POPULATION OF ALAMEDA COUNTY

I. HISTORY

In early 1979, representatives from the sexual minority community in Alameda County petitioned the Mental Health Advisory Board for inclusion in the County Mental Health planning process. The Advisory Board was receptive; however, since the three-year planning cycle was near completion, the Board's committees were reluctant to include new participants. Therefore, the Ad Hoc Committee on Sexual Minorities (with representation from the MHAB, providers of service, consumers, and citizens, some gay, some non-gay) was established to include gay representation in the County Mental Health planning process, as well as to ascertain the needs of sexual minorities in Alameda County and to identify types of services appropriate to meet those needs. Members of the Ad Hoc Committee will pursue representation in established Planning Committees in the near future.

ISSUE STATEMENT

> "The Task Force has found that homosexual men and women are represented in all age groups, social-economic classes, racial and ethnic groups, educational levels, and employment categories. They are an integral part of our society."
>
> From a study done by the Oregon Task Force on Sexual Preference.

As the visibility of gay people in our society has continued to increase, so has our awareness of the specialized problems which they face. This is particularly true in the Bay area where the percentage of gay people (estimated at between 12-18% of the population) is significantly higher than that of the general U.S. population. In Alameda County, there are at least 120,000 sexual minority members.

Research has consistently shown that only a small number of the gay population would seek a change in their sexual orientation if some mechanism for effective change were available. Therefore, a large number of gay persons seeking mental health assistance must be approaching the helping professions with concerns other than their sexual orientation. Yet it is an accepted fact that gay persons in a non-gay treatment milieu will be primarily treated for their "gayness" and not for the depression, anxiety, loneliness, etc., for which their non-gay counterparts are treated. Until this situation is rectified by cultural change and the education of non-gay mental health professionals, there will continue to be a need for mental health services <u>to</u> gay people, <u>by</u> gay people.

II. INSTRUMENTS

The Committee selected four primary sources from which to assess the particular needs of the sexual minority community in Alameda County: a United Way funded survey entitled "Service Needs of the Bay Area Gay/Lesbian Community"; a Committee-sponsored survey; comments of community professionals and leaders; and general documents pertaining to the specialized needs of the Gay community. (Specific information regarding documentation can be obtained through the Planning Office.)

A. United Way survey, Service Needs of the Bay Area Gay/Lesbian Community, was compiled by two faculty members of the School of Social Welfare at the University of California at Berkeley and one faculty member of the School of Social Work at University of California at Sacramento. The researchers surveyed residents of the greater Bay area (San Francisco, Alameda, Marin, Contra Costa, and San Mateo) during 1977. Collected data include responses from 394 gay persons, and 41 caseworkers and administrators of 29 human service agencies funded by United Way. 23.6% (92N) of the Gay respondents were from Alameda County, almost equally divided between males and females (45 males, 47 females). The document is the most comprehensive study to date which addresses the service needs of Gay people in the Bay Area. The Committee felt that the results of this survey, although it spanned five counties, were probably indicative of the current situation in Alameda County.

B. Committee Sponsored Survey - In an effort to validate the United Way study, the committee developed an independent questionnaire to sample the attitudes of Gay residents in Alameda County. One member of the committee headed a small team of interviewers who survey 75 potential consumers of Alameda County services. The interviews were conducted at A Women's Place Bookstore, Berkeley, the on-campus Women's Center at the University of California, Berkeley, local gay taverns, and at the Pacific Center, a mental health and social service agency for sexual minorities in Berkeley.

C. Comments of Community Professionals and Leaders - The committee solicited comments from professionals in the Mental Health field, both Gay and non-Gay as well as from a number of community leaders familiar with the needs of the sexual minority community.

D. General documents on the specialized needs of the Gay community - The committee reviewed, among other documents, the Preliminary Report of the Task Force on Sexual Preference to the Oregon State Legislature, the final report of the NIMH Task Force on Homosexuality, various articles from the Journal of Homosexuality, and other periodicals and research documents relevant to the study.

III. RESULTS

The mental health needs of sexual minorities have been largely ignored by existing mental health, medical, and community service agencies. While sexual minorities constitute a significant percentage of the overall population, the vast majority of mental health professionals and community services workers feel inadequately prepared to deal with the personal problems of these people. In the words of the United Way study:

> "(There) is little reason for the gay/lesbian community to be optimistic that their service needs will be addressed by traditional Bay Area agencies."

A. SERVICE NEED VS. SERVICE USE

The United Way report found that among the Gay respondents "service need was reported much than service use," and that "the non-availability of services was the most frequently cited reason for not using services." In interviews with agency personnel, the investigators discovered that "few agencies reported that they provide any special service to gay/lesbian clients and few have any plans to do so in the future." Among the same respondents, "expansion of gay/lesbian-operated services centers" was selected as the first of several options for increasing services to gay/lesbian people.

B. CLIENT/CLINICIAN MATCH

As with any group that has had a history of discrimination and oppression, there is a general mistrust of existing traditional agencies among sexual minorities. It is not the clinical competence of the agency that is mistrusted, but rather their social ignorance of the sexual minority subcultures, and repeated patterns of making value judgments concerning a client's sexual orientation. Over 79% of the Gay respondents in the United Way study reported that there are "important difficulties in the use of heterosexual counselors." The report further stated that "the prime difficulty was said to be a lack of information about and an understanding of gay/lesbian people." 65% of the respondents of the Committee sponsored survey reported "fair" or "poor" therapeutic experience with traditional mental health services, whereas in current pursuit of mental health assistance, 68% sought out a Gay counselor, and 84% of these respondents report a "good" or "excellent" level of satisfaction with their counseling experience.

C. MAINSTREAM PSYCHIATRIC ATTITUDES VS. CLIENTS' ATTITUDE

Sexual minorities have almost exclusively been treated in terms of pathology by the mental health professions. Therefore, the primary clinical efforts directed at the sexual minority client have been to eradicate or "cure" the client's sexual orientation. Regardless of the accuracy of the pathology theory, the fact remains that most sexual minorities do not wish to have their behavior changed.

(92% of the respondents of the Committee survey expressed satisfaction with their sexual orientation), and without a desire for a "cure," no cure is possible.

Recent years have seen a growth of a new school of thought about homosexuality. The American Psychiatric Association and the American Psychological Association in 1974 both removed "homosexuality" from their lists of "diseases." As T. Saghis pointed out in "Medical Aspects of Human Sexuality" (February, 1975), "the purpose in counseling the homosexual is ... to support him by helping him mature, cope, and stabilize behaviorally and emotionally, most often within the context of remaining a homosexual." Similarly, the NIMH Task Force report concluded: "In general, the goal of treatment for homosexual patients, as for others, must be the decrease of discomfort and the increase in productive functioning." However, old attitudes and misinformation persist, which is what prompted T. Maurer, in the July, 1975 issue of Postgraduate Medicine to write "Probably the most ethical decision a biased professional can make is to refer a homosexual to a therapist or professional who has no difficulty accepting homosexuals."

A recent survey of American Psychiatric Association Members (Sample - 2,500) conducted by Medical Aspects of Human Sexuality showed that 69% of the sample still believed that "homosexuality is usually a pathological adaptation as opposed to a normal variation." Thus, it appears that ongoing educational/consultation training to non-Gay mental practitioners is still needed.

D. PROBLEMS OF SERVICE DELIVERY

As the Committee reviewed the literature in the field, other specific elements emerged in the problem of service delivery to the sexual minority community.

The adverse effects upon a person's mental health, when that individual is forced to be at odds with society due to homosexuality are substantial. Psychiatric preoccupation with the disease concept of homosexuality conceals the fact that homosexuals are a group of medically stigmatized and socially persecuted individuals. Lacking a variety of tools with which they may enhance and improve their lifestyles, many sexual minorities fall into a cycle of loneliness and alienation. "Individual homosexuals suffer in being isolated from much of society and from the fact that they live in a culture in which homosexuality is considered maladaptive and opprobrious." (NIMH, p. 2) Consequently, sexual minorities are confronted with a series of unique problems stemming from societal oppression and neglect which include:

1. "Coming out" issues of persons trying to adapt to their sexual orientation.

2. Estrangement from heterosexual people who have difficulty accepting a gay relative, friend, or co-worker.

3. Discrimination issues in employment and housing.

4. Alcohol and drug abuse (since much of the social life of the Gay community revolves around bars, these have become major problem areas).

5. Relationship issues differing in some respects from the conventional issues in heterosexual relationships.

6. Chronic depression among those individuals who are most acutely vulnerable to societal oppression because of their homosexuality.

E. EXISTING SERVICES

Letters and responses (which are available upon request) from community members, political leaders, and service providers in the County of Alameda concur that services for sexual minorities are inadequate. Only one facility in Alameda County addresses the particular mental health and social service concerns of sexual minority clients. The facility, Pacific Center for Human Growth, is hard pressed to meet the overwhelming demand for service, due to insufficient funding support needed to expand its programs. Private foundations have largely been reluctant to fund Pacific Center, due to the sexual orientation of its clients. Other services are available to the Gay community on a limited basis. Berkeley Mental Health, Berkeley Place, and the Center for Independent Living have consulted with the Pacific Center in an effort to establish improved service delivery to their Gay clients.

F. SERVICE GAPS

The most prominent service gaps appear in the areas of specialized training, employment programs, and emergency crisis care for sexual minorities in acute need. The Pacific Center does offer a comprehensive training program to professionals and paraprofessionals - yet many well-established mental health agencies have been reluctant to use its services. The purpose of specialized training is to acquaint professionals with important aspects of the therapeutic relationship between clients and therapists of different sexual orientation, and to orient professionals to the differences between gay subcultural influences and those of the core culture.

A survey of Alameda County Mental Health agencies conducted by the Pacific Center indicated that some service providers were receptive to the concept of specialized training, although most expressed ambivalence.

Most respondents (68%) of the community surveys reported that they had experienced employment discrimination due to their sexual orientation. The Civil Rights Ordinance of the City of Berkeley and the City and County of San Francisco support these findings; each prohibits discrimination in employment and housing based upon sexual orientation. Moreover, the respondents surveyed indicated that specialized employment services for Gay people were unavailable, and that the need for such programs was great.

Of the respondents who indicated previous therapeutic experiences, the majority reported "fair" or "poor" experiences in the use of emergency crisis facilities.

G. PARTICIPATION OF MINORITIES IN PLANNING

Perhaps the most important finding in this survey is the lack of participation of Gay advocates in the planning process. The executive director of the Pacific Center for Human Growth states, "I have become increasingly disturbed about the exclusion of sexual minorities from the County Plan. I am equally disturbed about the absence of representation or advocacy for this community's interests on County Advisory Committees and Commissions."

Another mental health professional in Alameda County comments: "The need for expanded Gay services in Alameda is obvious. Gay people need to have access to social and mental health services that are responsive to their particular needs. This can only be accomplished by including Gays in planning for the County."

An Alameda County Board of Supervisors member states, "I am writing in support of the inclusion of sexual minority input in the mental health planning process of Alameda County. Though statistics are not available, it is obvious that members of sexual minorities are becoming an increasingly significant population group in Alameda County and the Greater Bay Area."

A letter of recommendation from the Board of Supervisors in 1976, correspondence from Alameda County Mental Health agencies, and the Director of Planning for the Association of Bay Area Governments support the Pacific Center Executive Director's statement quoted above. All call for the inclusion of this significant population in the planning process in order to address the enormous, unmet needs of this community.

H. SUMMARY OF RESULTS

In analyzing the results of the aforementioned surveys, the committee reached the following conclusions:

1. Cultural discrimination against Gay people in and of itself produces a broad range of specialized service needs for the Gay community.

2. The goal of providing treatment to sexual minorities should not, in most instances, involve altering their sexual orientation.

3. Most non-Gay counselors are currently unequipped to deal effectively with the specialized needs of Gay people.

4. Traditional Bay Area Service agencies, are, by and large, currently unable/unwilling to address the needs of the Gay community.

5. The Gay community is presently underserved by existing service agencies.

6. The Gay community is seriously under-represented in the County planning processes for mental health services.

7. It is not the clinical competence of traditional agencies that is mistrusted, but rather their social ignorance of the sexual minority subcultures, and repeated patterns of making value judgments concerning a client's sexual orientation.

IV. RECOMMENDATIONS BASED ON MENTAL HEALTH NEEDS ASSESSMENT (NOT PRIORITIZED)

This Committee arrived at the following recommendations as a result of the conclusions reached in the needs assessment survey of the Gay community in Alameda County.

A. In the immediate future, it is critical that full support be given to the survival and expansion of existing direct service programs sensitive to the needs of the Gay community. These services include: Counseling, Drug Abuse, Alcoholism, Emergency Crisis Care, and Employment.

Two critical themes emerge repeatedly throughout this document:

1. *Specialized services for sexual minorities are rare.*
2. *The demand for such services is overwhelming.*

A crisis facility designed to treat Gays in acute need is essential in view of the medical establishment's poor track record with these individuals. Employment difficulties and life adjustment problems often lead to major psychological breakdowns or the manifestations of a variety of negative escape techniques.

B. That existing non-Gay mental health services and programs be adapted to the specialized needs of the Gay community. This can be accomplished in two primary ways:

1. By developing mandatory training programs for staff and administrators in non-Gay mental health agencies.
2. By encouraging the hiring of openly gay staff in these agencies.

The purpose of training would be to familiarize members of the helping professions with the particular needs of their gay clients. The training programs, conducted by gay professionals and community members, would focus upon sexual minority community attitudes, clinical considerations, relationship patterns, families and subcultural terminology and mores.

C. That future County contracts be awarded to only those human service agencies which demonstrate a willingness to improve their service delivery to sexual minority clients.

D. That the sponsoring community education projects/activities (workshops, seminars, publications, etc.) concerning sexual minorities be encouraged and pursued by the County.

There is a need for accurate information concerning homosexuality in order to eliminate and demystify negative stereotypes and prejudices concerning sexual orientation. Significant outreach into the community at large is essential in order to sensitize institutions as well as to educate the general public.

E. That services designed to prevent mental health crises among sexual minorities be accorded high priority consideration.

The focus here is not on programs which attempt to "cure" homosexuality, rather on those which regard homosexuality as a normal variation of sexual orientation.

D. That visible representation from the Gay community be included in all governmental levels of the planning process to provide mental health services in Alameda County.

A representative of the Association of Bay Area Governments states: "... Gay people should be given particular importance in planning at this time. To date, services have not been designed to address their special needs. For too long, the social stigma attached to sexual minorities has pervaded traditional social services. Consequently, gay people have either been denied services or have resisted using them because their needs would not be adequately addressed. To correct this, services need to be restructured and those who administer them need counseling and advice. The concerns, anxieties, and illnesses of gay people are no less real -- nor less responsive to professional treatment -- than those of others. But we need to be sensitive to them and realize that the differences

that may exist are only differences, not moral or insoluble problems. Alameda County is urged to recognize sexual minorities and respond positively to involving them in all aspects of planning in the County as it has for other minorities in the past."

The following is a summary of future and new expanded programs designed to meet the mental health needs of Alameda County residents. This summary was presented in the Alameda County Short-Doyle Plan, 1977-78 and has been updated for the 1979-80 Short-Doyle Plan.

KEY: * Program Implemented
** Program in Progress
*** Included in Submitted Proposal for CRTS Funding

SUMMARY OF FUTURE NEW AND EXPANDED PROGRAMS
NECESSARY TO MEET MENTAL HEALTH NEEDS

24-Hour Services

Target Population	Program Type	Program Description
Acutely ill	*1. Inpatient, 24-hour acute care.	16-20 bed inpatient service to the mentally disordered offender.
"	*2. Inpatient, 24-hour acute care.	10 beds contracted at Gladman Hospital.
"	3. Inpatient, 24-hour acute care.	15-20 bed acute inpatient services for Southern Alameda County.
"	4. Inpatient, 24-hour acute care.	Expansion of HPIS by 6 beds to relieve impaction problems at Napa State Hospital.
"	**5. Inpatient, sub-acute skilled nursing facility.	Program augmentation for 99-bed psychiatric skilled nursing facility (program proposed and partially funded in 1976-77).
"	**6. Inpatient, sub-acute skilled nursing facility.	75-bed long-term chronic care geriatric facility.
"	7. Emergency room/ crisis intervention.	Contract with Valley Memorial Hospital for emergency and crises intervention services to Livermore-Pleasanton area (Southern Region).
"	8. Crisis intervention and emergency.	Staff augmentation to County psychiatric emergency services, existing half-way houses and expansion of hours for community crisis clinics.

Target Population	Program Type	Program Description
Children	9. Short-term crisis, residential.	For children and youth secure non-hospital crisis intervention to include evaluation and 6 acute 24-hour care (10 beds, residential) with bilingual/ bicultural capability and capability of serving handicapped children.
"	10. Residential, 24-hour care.	Two group homes for mentally disturbed adolescents.
Minorities	11. Inpatient, residential.	Specialized, language specialized half-way houses for minority populations, Asians, Latino, etc., with multi-lingual capability.
	OUTPATIENT, CE&I	
Adult and Children	1. Outpatient, rehabilitative services.	Augmentation to existing adult and children's outpatient services, allowing for expanded services; hours to include nighttime and weekends; increase services to minorities and improve affirmative action efforts.
Chronically Mentally Ill	***2. Partial day socialization and activity center.	Daytime activity centers for adult mentally ill. Model centers patterned after Creative Living Centers under contract with the Social Services Bureau.
"	*3. Case management.	Development of case management system.
"	*4. Conservatorship.	Full-time psychiatrist for provision of expert testimony to courts (Physician III and Investigation Services). Program relates to care of chronically mentally ill and case management.

Target Population	Program Type	Program Description
Chronically Mentally Ill	5.	Contract with Board and Care Homes for specialized services to specific client populations.
Children	6. Outpatient services.	Expansion of current children's services to increase capacity for family therapy, evaluation and referral, direct treatment and indirect, consultative services to local school districts.
"	***7. Partial day group and family therapy.	Six children and/or adolescent day treatment services. Geographically scattered throughout Alameda County to allow easy accessibility and provide socialization, recreation and therapeutic intervention on a daily basis. Programs must have bilingual/bicultural capability as well as capability to serve handicapped children.
Criminal Justice	8. Outpatient, aftercare.	Criminal justice aftercare at Santa Rita County Jail to include outpatient follow-up on on-site triage to reduce rate of regression and hospitalization. Must have bilingual/bicultural capability.
"	9. Outpatient residential prevention aftercare.	Specialized service to criminal justice patient in pre-trial environment and patients subsequently found to be Penal Code 1370. 1026 or M.D.O. Include short-term crises intervention in a jail setting and direct placement and supervision in appropriate residential facilities.
Minority	10. CE&I, outreach prevention.	Outreach CE&I to ethnic minority by contract to El Centro, La Familia and Asian Community Mental Health and all community contract services and specialized County services. Program augmentation would include initial screening and assessment.

Target Population	Program Type	Program Description
Elderly	**11. Outpatient, crises intervention, family therapy.	Transportation, equipment and drivers for elderly patients for crisis intervention transportation to daycare facilities and programs. Program would be accessible to minorities and handicapped.
Handicapped	12. Outpatient, treatment, prevention, aftercare.	Outpatient services to the physically handicapped, blind, deaf and physically impaired persons. Program to be integrated with the Center for Independent Living.
Administration	13. Administration, fiscal/program.	Augmentation to administrative services requested by programs herein stated to include financial services, program administration, outside computer time.
"	14. Administration, research/evaluation.	To augment generalized evaluation services of County and contract programs and engage in specific research studies, i.e. outcome, measurement, allocation models, etc.
	15. CE&I	Patients' right and advocacy program to provide linkages, i.e. consultation, education to agencies and services outside of the County mental health programs. Services would have bilingual/bicultural capability and serve the handicapped population.
Chronically Mentally Ill	16. CE&I	Augmentation to placement unit services.
	17. CE&I	Clinical psychopharmacologist with staff support to monitor use of psychotropic medications, education of physicians, consultation with service providers and patients, i.e. board and care operators, skilled nursing facilities.

Target Population	Program Type	Program Description
Suicide	18. CE&I, counseling prevention.	Program expansion for Suicide Prevention of Alameda County to extend full service to Livermore/Pleasanton Valley area.
Developmentally Disabled	19. Outpatient, counseling/ prevention	Prevention of family breakdown and mental disability occasioned by the birth of a developmentally disabled child or unusual stresses related to the growing-up process of such a child.
	20. CE&I	Community education program including pamphlets, television and radio spots, public relations, etc., to inform communities of services available through mental health services. In conjunction with other agencies and services in the community.
Children	21. Prevention.	Model therapeutic nursery for children.
Elderly	22. Outpatient, outreach aftercare, crisis intervention.	Specialized board and care homes for elderly to include local activity centers, mobile outreach services to provide day treatment services and assistance to existing nursing and convalescent homes for elderly at risk of hospitalization. Program would be integrated with Public Health Services to the elderly.

This section contains, for each Alameda County Mental Health Service, contracted and Agency operated, the following:

1. Form E: Brief fiscal and programmatic information

   This information is preliminary and revisions will be forthcoming with the September submission of the Cost Reporting/ Data Collection (CR/DC) document.

   Where data is currently available, demographic data by ethnicity from the 1970 Census and service site utilization data (based on percentage of discharge, Services Assessment Summary Report July 1, 1977 to June 3, 1978) by ethnicity is included.

   The following abbreviations are used in the form:

MD	Mentally Disordered
DD	Developmentally Disabled
MDO	Mentally Disordered Offender
DA	Drug Abuse

2. Staffing pattern survey*:

   Documentation of positions, ethnicity of staff and language capability as of February 1979 and therefore may be subject to changes or modifications.

   The following abbreviations are used:

s/a	Supervisory/Administrative
ds	Direct Service
c	Clerical

   The information will be analyzed and utilized as part of the Affirmative Action Plan for Alameda County Mental Health Services.

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* Because of some design difficulties, the staffing pattern survey is being re-done and will be available upon completion.

Section III
Table of Contents

HIGHLAND PSYCHIATRIC INPATIENT - 0101*

	1977-78 Past Year Actual	1978-79 Estimated Current Year	1979-80 Estimated Budget Year
Unduplicated Clients Served Per Year	DATA NOT AVAILABLE		
Program Cost	D 3,432,784 I Total 3,432,784	3,185,115 3,185,115	3,012,333 3,012,333
% of Total County M.H. Budget	13.7	12.3	11.6
Units of Service	D 13,723 I	12,454	12,908

DEMOGRAPHIC CHARACTERISTIC (1970 CENSUS) OF AREA SERVED

	Number	% of Area	% of Discharge from service site
Indian	5,688	01	Data not presently
Black	161,282	15	available
Chinese			
Filipino			
Japanese	40,786	04	
Spanish			
White	135,028	13	
Other	720,949	66	
	9,450	01	

DATA FOR 1979/80

Age Group Treated: 0-65+

Target Group(s): MD

*Excludes Highland Hospital based Acute Inpatient Criminal Justice Program

HIGHLAND PSYCHIATRIC INPATIENT - 0101

Primary Problems Treated: People who are considered to be a danger to themselves or others or gravely disabled. Those in the acute stages of mental disorder who do not meet the above criteria but for whom alternatives to treatment in Highland Psychiatric Emergency Service are considered inadequate and inappropriate.

Program Objectives:

1. Provide 24-hours per day inpatient psychiatric services.
2. Provide on an ongoing basis the availability of 40 acute beds and to maintain occupancy at a rate of more than 85%.
3. Ensure that each patient is given a thorough medical examination within 24 hours of admission.
4. To evaluate, diagnose, and set up treatment plans on each patient within 72 hours following admission.
5. To coordinate and effect acute hospitalization of patients into Short-Doyle inpatient beds at Highland Inpatient, Napa State Hospital, and Gladman Hospital in coordination with both Highland and Fairmont Hospitals Psychiatric Emergency and the Mental Health Specialized Service Unit.
6. In coordination with all available agencies, reduce and/or eliminate utilization of acute beds by psycho-geriatric patients to the extent clinically appropriate.
7. To provide stabilization and treatment planning, extended crisis intervention, supportive therapies, patient education, placement and discharge planning.

Estimated Average Duration of Treatment:

1. Geriatric patient, 24.3 days
2. Adolescent patient, 17.5 days
3. Criminal Justice patient, 3.0 days (overnight boarders skew this average)
4. All other patients, 9.5 days

What needs of a minority and/or handicapped population does this program meet and how? Efforts are made to maintain minority representation on staff and in-service training is provided concerning minority issues. Discharge planning includes culturally appropriate services, when available. Accessible to physically disabled. Interpreter services available for hearing impaired.

What unique need does this program meet? Highland Psychiatric Inpatient Service is the only County-operated inpatient facility in Alameda County. There are two inpatient wards with approximately twenty beds on each ward. The two wards have programs which specialize in the treatment of acute geriatric and adolescent patients.

Is your program designed to meet the mental health needs of any county's minority population? Through active recruitment of minority personnel the program meets the mental health needs of minority patients.

CRIMINAL JUSTICE PSYCHIATRIC INPATIENT

24-Hour Care

	1977-78 Past Year Actual	1978-79 Estimated Current Year	1979-80 Estimated Budget Year
Unduplicated Clients Served Per Year	DATA NOT AVAILABLE		
Program Cost	D 593,078 I Total	1,429,406	1,209,814
% of Total County M.H. Budget	2.4	5.5	4.6
Units of Service	1,982	4,508	4,870

DATA FOR 1979/80

Age Group Treated: 18-64

Target Group(s): MDO

Primary Problems Treated: Criminal Justice Inpatient Psychiatric Ward treats the whole spectrum of acute psychiatric disorders which necessitate hospitalizations. Additionally, the patients we treat are under the jurisdiction of Alameda County Sheriff's Department.

Program Objectives: The program is designed to give in-county acute psychiatric care for inmates who need inpatient treatment. It is imperative that this population receives comparable treatment as is given the general population. In some cases, we are able to divert individuals from the criminal justice system and in selective cases that is an additional goal.

Estimated Average Duration of Treatment: 8-10 days

What needs of a minority and/or handicapped population does this program meet and how? Staff and patient population are multi-ethnic. There have been only 2 patients physically handicapped; both patients were amputees and walked with crutches. No special provisions had been made for their care.

What unique need does this program meet? See above.

How is your program designed to meet the mental health needs of any county's minority population? Staff is racially mixed. Efforts are continually made to recruit and retain staff representative, ethnically and culturally, of the patient population.

STATE HOSPITALS - 0004

24-Hour Care

	1977-78 Past Year Actual	1978-79 Estimated Current Year	1979-80 Estimated Budget Year
Unduplicated Clients Served Per Year	DATA NOT AVAILABLE		
Program Cost	D I Total 6,979,340	7,277,205	5,593,820
% of Total County M.H. Budget	27.9	28.2	21.5
Units of Service	106,283	79,432	69,817

DATA FOR 1979-80

Age Group Treated: 0-65+

Target Group(s): MD

Primary Problems Treated: Acute exacerbations of chronic illnesses and need for long-term hospitalization for purpose of stabilization and rehabilitation.

Program Objectives: Stabilization of acute psychotic episodes; rehabilitation of chronic illness for purposes of placement and/or re-entry into the community for adults, adolescents, and children.

Estimated Average Duration of Treatment: Generally 4 to 12 weeks.

What Unique Need Does This Program Meet? Provides short-up to eight weeks) and long-term (six months to one year) treatment for seriously disordered adults; acts as back up to local hospital beds; serves as long-term treatment facility for adolescents and children.

LAUREL HOUSE (SUB-ACUTE) - 0102

24-Hour Care

	1977-78 Past Year Actual	1978-79 Estimated Current Year	1979-80 Estimated Budget Year
Unduplicated Clients Served Per Year	DATA NOT AVAILABLE		
Program Cost	D 24-hr 76,013 I Partial 206,074 Total	80,008	84,008
% of Total County M.H. Budget	.3 .8	.3	.3
Units of Service	D 24-hr 4,710 I Partial 4,710	5,256	5,256

DATA FOR 1979/80

Age Group Treated: 18-64

Target Group(s): MD

Primary Problems Treated: To provide quality, short-term mental health services to those in need of residential treatment during an acute or post-acute period, thus avoiding unnecessary or inappropriate hospitalization. All clients come from a hospital setting; primary intake resources are Highland Psychiatric Inpatient Service and Napa State Hospital.

Program Objectives:

1. Residential treatment and care: To operate a licensed, non-medical facility at least at 80% capacity, 24-hours-a-day, serving up to 18 persons a day with an average stay of about 21 days and maximum stay of 45 days.

2. Individual treatment plan: An individual treatment plan will be developed with each resident within 3 days. It will be reviewed weekly for needed modification by assigned staff.

3. Discharge Planning: Staff will develop discharge plans; shall include referral for follow-up care at a mental health center or with the private sector. Assigned staff shall coordinate the initial contact with the program therapist prior to discharge in all cases other than those persons discharged to a hospital or locked facility, or who refuse further treatment services.

LAUREL HOUSE (SUB-ACUTE) - 0102

Estimated Average Duration of Treatment: 21 days

What needs of a minority and/or handicapped population does this program meet and how? Need for a non-medical sub-acute facility (e.g. Highland Study 1975) by providing a three-week intensive program during acute, post-acute period; by providing individual and group counseling, advocacy, recreation and socialization groups, crisis intervention, medication evaluation/supervision, discharge planning and follow-up care; also a Day Treatment Program.

What unique need does this program meet? A non-hospital, residential treatment facility for patients who would otherwise require prolonged hospitalization.

How is your program designed to meet the mental health needs of any county's minority population? Although not designed to serve any one minority population exclusively, an integrated bilingual limited number of staff with sensitivity to bicultural concerns serves minorities in Alameda County (over 40% of clients served are minority).

LAUREL HOUSE (SUB-ACUTE) - 0102

Partial Day Care

	1977-78 Past Year Actual	1978-79 Estimated Current Year	1979-80 Estimated Budget Year
Unduplicated Clients Served Per Year	DATA NOT AVAILABLE		
Program Cost	D I Total N/A	204,702	230,270
% of Total County M.H. Budget	N/A	.8	.9
Units of Service	N/A	5,256	5,256

DATA FOR 1979/80

Age Group Treated:*

Target Group(s):*

Primary Problems Treated:*

Program Objectives:

Estimated Average Duration of Treatment:*

What needs of a minority and/or handicapped population does this program meet and how?*

What unique need does this program meet?*

How is your program designed to meet the mental health needs of any county's minority population?*

*Please refer to Laurel House (Sub-Acute), 24-Hour Care

CANYON MANOR (SUB-ACUTE) - 0107

24-Hour Care

	1977-78 Past Year Actual	1978-79 Estimated Current Year	1979-80 Estimated Budget Year
Unduplicated Clients Served Per Year	DATA NOT AVAILABLE		
Program Cost	D 18,930 * I Total 18,930	43,303 43,303	45,468 45,468
% of Total County M.H. Budget	.1	.2	.2
Units of Service	681	1,460	1,460

DATA FOR 1979/80

Age Group Treated: 18-64

Target Group(s): MD

Primary Problems Treated: This subacute treatment facility, as an alternative to hospitalization, provides treatment for psychiatric symptomotology and inadequacies in social and basic living skills in order to achieve optimal functioning and return to the community.

Program Objectives:

A. Stabilization of psychiatric condition.
B. Improved functioning level of patients in activities of daily living and social functioning.
C. Allow for return to community in a less restrictive setting
D. Minimize risk of need for future hospitalization.

Estimated Average Duration of Treatment: 36 months.

What needs of a minority and/or handicapped population does this program meet and how? We admit all minorities who are mentally disabled and appropriate for our treatment program (i.e. chronic mentally ill). We have bilingual capability in Spanish and German. We can serve the blind and visually impaired mentally disordered clients. No wheelchair capability or capability to serve the deaf. A special vocational counselor is provided, when necessary, to assist a blind or visually impaired client to use the facilities.

*Program started mid-year

CANYON MANOR (SUB-ACUTE)

What unique need does this program meet? 24-hours skilled nursing care and 12-hours psycho-social treatment per day.

How is your program designed to meet the mental health needs of any county's minority population? Although admission to this program is open to all residents of Alameda County, this program is not specifically designed for any particular ethnic minority group. Staff represents various ethnic backgrounds.

Note: narrative summary combines both Mental Health management day treatment and Marin County SART residential treatment component of the Canyon Manor Program.

Partial Day Care

	1977-78 Past Year Actual	1978-79 Estimated Current Year	1979-80 Estimated Budget Year
Unduplicated Clients Served Per Year	DATA NOT AVAILABLE		
Program Cost	D 211,696* I Total 211,696	401,500 401,500	421,575 421,575
% of Total County M.H. Budget	.8	1.6	1.6
Units of Service	11,940	16,060	16,060

DATA FOR 1979/80

Age Group Treated:**

Target Group(s):**

Primary Problems Treated:**

Program Objectives:**

Estimated Average Duration of Treatment:**

What needs of a minority and/or handicapped population does this program meet and how?**

What unique need does this program meet?**

Is your program designed to meet the mental health needs of any county's minority population?**

*Program started mid-year
**Please refer to Canyon Manor (Sub-Acute), 24-Hour Care

FAIRMONT PSYCHIATRIC EMERGENCY - 0112

Outpatient Care

	1977-78 Past Year Actual	1978-79 Estimated Current Year	1979-80 Estimated Budget Year
Unduplicated Clients Served Per Year	Data Unavailable	Data Unavailable	Data Unavailable
Program Cost	D 658,302 I Total 658,302	545,028 545,028	619,182 619,182
% of Total County M.H. Budget	2.6	2.1	2.4
Units of Service	3,440	3,524	3,483

DEMOGRAPHIC CHARACTERISTIC (1970 CENSUS) OF AREA SERVED

	Number	% of Area	% of Discharge from service site
Indian	2,032	.4	.4
Black	6,684	1.0	6.4
Chinese)			
Filipino)	9,804	2.0	.7
Japanese)			
Spanish	84,648	17.0	9.8
White	391,036	78.0	81.9
Other	4,108	.8	.8

DATA FOR 1979/80

Age Group Treated: 0-65+

Target Group(s): MD, DA

Primary Problems Treated: Fairmont Psychiatric Emergency Service has the responsiblity for receiving, evaluation, treating (on a brief basis) and making appropriate therapeutic disposition for all persons referred from the community for immediate psychiatric attention. Included in this population

are the major psychotic disorders, suicide attempts, depression, disordered behavior resulting from the use of drugs and alcohol, the problems associated with diminished ability resulting from the mental deterioration of old age, as well as the distress of marital and other interpersonal difficulties.

Program Objectives: To provide immediate intervention to persons in need of psychiatric assistances at any time. To continue the maintenance and development of linkages with the various other facilities in Alameda County, both public and private.

Estimated Average Duration of Treatment: One to six hours.

What Needs of a Minority and/or Handicapped Population Does this Program Meet and How? The most sizable minority population is Hispanic. Spanish speaking staff is able to meet emergency needs; follow-up arranged with outpatient Spanish speaking therapists, or ethnic services. Because of Fairmont Hospital's Physical Rehab and Speech Pathology and Audiology programs, staff is sensitized to needs of persons with disabilities and uses staff of these programs as consultants.

What Unique Need Does this Program Meet? We are the only fully psychiatric emergency service with full medical backup and six holding beds in the South Region of Alameda County.

Is Your Program Designed to Meet the Mental Health Needs of any County's Minority Population? Indirectly. As stated, this program is especially accessible (psychologically and physically) to the Hispanic and/or disabled population.

HIGHLAND PSYCHIATRIC EMERGENCY - 0101

24-Hour Care

	1977-78 Past Year Actual	1978-79 Estimated Current Year	1979-80 Estimated Budget Year
Unduplicated Clients Served Per Year	DATA NOT AVAILABLE		
Program Cost	D 1,708,783 I Total 1,708,783	1,350,089 1,350,089	1,451,576 1,451,576
% of Total County M.H. Budget	6.8	5.2	5.6
Units of Service	D 8,094 I	7,980	8,384

DEMOGRAPHIC CHARACTERISTIC (1970 CENSUS) OF AREA SERVED

	Number	% of Area	% of Discharge from service site
Indian	5,688	01	.4
Black	161,282	15	47.3
Chinese			.9
Filipino	40,786	04	.4
Japanese			.4
Spanish	135,028	13	4.4
White	720,949	66	45.6
Other	9,450	01	.5

DATA FOR 1979/80

Age Group Treated: 0-65+

Target Group(s): MD

Primary Problems Treated: Voluntary or involuntary patients who are considered to be a danger to themselves or others or gravely disabled. Patients in the acute stages of mental disorder who need immediate care.

HIGHLAND PSYCHIATRIC EMERGENCY - 0101

Program Objectives: Provide a continuum of services which includes emergency evaluation and treatment at the rate of approximately 8,300 emergency units per year. To hold patients on a six bed unit for up to 24 hours duration for purposes of observation, emergency treatment and disposition at a rate of up to 180 "holding days" per month. To provide admission processing for all patients being admitted to the Inpatient Units at a rate of 180 patients per month. To add staff in order to increase the holding bed capacity from six to ten beds thereby increasing the "holding days" from 180 to 300 per month.

Estimated Average Duration of Treatment: 4-6 hours.

What needs of a minority and/or handicapped population does this program meet and how? Close ties are maintained with ethnically-oriented mental health clinics such as El Centro and Asian Mental Health Services and appropriate County-operated services focusing on ethnic/minority services and needs. An attempt is always made to identify and utilize treatment resources in patient's language.

What unique need does this program meet? Immediate short-term acute psychiatric service to all residents of Alameda County who cannot afford private hospital care.

Is your program designed to meet the mental health needs of any county's minority population? See above.

SOUTH REGION DAY TREATMENT SERVICE - 0112

Outpatient Care

	1977-78 Past Year Actual	1978-79 Estimated Current Year	1979-80 Estimated Budget Year
Unduplicated Clients Served Per Year	DATA UNAVAILABLE	DATA UNAVAILABLE	DATA UNAVAILABLE
Program Cost	D 347,990 I 14,114 Total 362,104	345,203 22,251 367,454	295,320 20,723 316,043
% of Total County M.H. Budget	1.4	1.4	1.2
Units of Service	D 4,177 I 607	3,992 712	3,979 592

DATA FOR 1979-80

Age group Treated: 18-65+

Target Group(s): MD

Primary Problems Treated: 1) Persons at risk of psychiatric hospitalization due to their acute psychiatric condition. 2) The more chronic clients who are actively moving through the community and Mental Health Service system (board-and-care facilities, half-way houses, jails, hospitals). This person's history most often will include failure to seek follow-up care once discharged from the hospital.

Program Objectives: 1) To significantly reduce all acute psychiatric symptoms with medical/psychiatric and therapeutic milieu support. 2) To assist each individual to move toward improved social functioning and to avoid socially maladaptive behavior which often results in extended psychiatric hospitalizations. 3) To educate individuals regarding the nature of their specific psychiatric symptoms and the nature of their effective treatment. 4) To maintain an average caseload of 45 and average daily attendance to 30.

Estimated Average Duration of Treatment: Thirty days for acute; one year plus for intermediate clients.

What needs of a minority or handicapped population does this program meet and how? 1) Spanish language capability. 2) Limited physical access. 3) Availability of interpreters for hearing-impaired clients.

What unique need does this program meet? It is the only partial hospital program in the southern half of Alameda County. It provides a community-based therapeutic milieu for both the acute and intermediate client.

Is your program designed to meet the mental health needs of any of the county's minority population? In general, our program is designed to meet the needs of the mentally ill, primarily through appropriate staffing which includes minority representation.

EDEN ADULT OUTPATIENT SERVICE - 0109

Outpatient Care

	1977-78 Past Year Actual	1978-79 Estimated Current Year	1979-80 Estimated Budget Year
Unduplicated Clients Served Per Year	Data Unavailable	Data Unavailable	Data Unavailable
Program Cost	D 276,792 I 155,048 Total 431,840	343,340 79,887 423,227	352,739 135,466 488,205
% of Total County M.H. Budget	1.7	1.7	1.9
Units of Service	D 7,571 I 2,294	10,428 1,304	8,234 1,814

DEMOGRAPHIC CHARACTERISTIC (1970 CENSUS) OF AREA SERVED

	Number	% of Area	% of Discharge from service site
Indian	997	.41%	0.9
Black	2,056	.84%	3.1
Chinese	4,825	1.96%	0.6
Filipino	Included in "Other"		
Japanese	Included in "Asian" (Chinese)		
Spanish	42,095	17.11%	9.9
White	193,701	78.75%	83.5
Other	2,285	.93%	1.9
	245,959	100.00%	

DATA FOR 1979/80

Age Group Treated: 18 - 65+

Target Group(s): MD

Primary Problems Treated: Persons with major mental disorder and history of psychiatric hospitalization; other problems producing risk of hospitalization; all others without access to treatment alternatives.

Program Objectives: Reduction of need for hospitalization; stabilization and maintenance of chronically ill in the community by providing outpatient psychotherapy and consultation, education and referral services.

Estimated Average Duration of Treatment: For long-term, chronic population, indefinite. For more acute disturbance, one to six months.

What Needs of a Minority and/or Handicapped Population Does this Program Meet and How? 1) Program has Spanish-speaking capability. 2) Building is accessible for physically handicapped. 3) Consultation with LaFamilia Counseling Service, the Filipino Immigrant Service and the Center for Independent Living in Berkeley (physically disabled) is provided where special needs and problems exist.

What Unique Need Does this Program Meet? It is the only public program providing direct and indirect outpatient services to adult citizens of the Eden area of Alameda County.

Is Your Program Designed to Meet the Mental Health Needs of any County's Minority Population? Yes, primarily through staffing and consultation with community agencies.

TRI-CITY ADULT OUTPATIENT - 0122

Outpatient Care

	1977-78 Past Year Actual	1978-79 Estimated Current Year	1979-80 Estimated Budget Year
Unduplicated Clients Served Per Year	DATA NOT AVAILABLE		
Program Cost	D 329,737 I 30,378 Total 330,115	328,608 24,762 353,370	347,040 34,023 381,063
% of Total County M.H. Budget	1.4	1.4	1.5
Units of Service	D 6,648 I 499	8,120 482	7,083 570

DEMOGRAPHIC CHARACTERISTIC (1970 CENSUS) OF AREA SERVED

	Number	% of Area	% of Discharge from service site
Indian	806	0.4	1.1
Black	1,626	0.7	3.3
Chinese	1,177	0.5	.4
Filipino	2,005	0.9	.0
Japanese	1,192	0.5	.0
Spanish	35,372	16.0	13.9
White	172,715	80.2	78.8
Other	1,508	0.6	2.6

DATA FOR 1979/80

Age Group Treated: 18-65+

Target Group(s): MD

Primary Problems Treated: Target population are those individuals who are at high risk of hospitalization. This includes: Those individuals with a history of psychiatric hospitalization and those individuals never hospitalized but at risk of requiring such care unless there is therapeutic intervention made available to them.

TRI-CITY ADULT OUTPATIENT - 0122

Program Objectives: To continue focus on the group therapy mode of treatment. To continue the utilization of day programs by referring patients needing additional support or specialized treatment approaches, thereby both providing appropriate treatment modalities in order to enhance and enrich the lives of patients in this area and to minimize the risk of hospitalization.

Estimated Average Duration of Treatment: For chronic, long-term, indefinite; for more acute disturbances, 1-6 months.

What needs of a minority and/or handicapped population does this program meet and how?

1. Facilities accessible to physically disabled.
2. Limited bilingual (Spanish) capability.
3. Availability of interpreter for hearing-impaired client.

What unique need does this program meet? This service is located in an area which includes the largest youth population, the fastest growth rate and a very high suicide rate. This is the only public mental health outpatient clinic providing services to the population 18 years of age and over, living in the Tri-City area and unable to use private care.

Is your program designed to meet the mental health needs of any County's minority population? The program has limited bilingual (Spanish) capability and is continuing efforts to increase the number of bilingual staff in order to serve the large Spanish population of the Tri-City area.

VALLEY ADULT OUTPATIENT - 0132

Outpatient Care

	1977-78 Past Year Actual	1978-79 Estimated Current Year	1979-80 Estimated Budget Year
Unduplicated Clients Served Per Year	DATA NOT AVAILABLE		
Program Cost	D 234,258 I 36,648 Total 270,906	248,479 37,948 286,427	273,702 46,163 319,865
% of Total County M.H. Budget	1.2	1.1	1.2
Units of Service	D 4,708 I 557	5,004 590	4,688 619

DEMOGRAPHIC CHARACTERISTIC (1970 CENSUS) OF AREA SERVED

	Number	% of Area	% of Discharge from service site
Indian	187	.003	0
Black	369	.005	8
Chinese)			
Filipino) Asian	916	.02	0
Japanese)			
Spanish	6,441	.09	2.3
White	61,338	.88	96.1
Other	421	.001	8

DATA FOR 1979/80

Age Group Treated: 18-65+

Target Group(s): MD

Primary Problems Treated: a) Those adult persons with a history of psychiatric hospitalization at either state, local or private facilities; b) those adult persons never hospitalized, but at risk of requiring such if they do not receive services; c) those adult persons never hospitalized and not necessarily at risk of such, but who are experiencing acute or chronic emotional disturbance; d) other

adult persons seeking mental health services for severe emotional disturbance.

Program Objectives: Principle objective is to provide an outpatient mental health program to restore those with emotional disorders to a more adequate level of functioning and/or to prevent further deterioration.

Estimated Average Duration of Treatment: For chronic, long-term, indefinite; for more acute disturbances, 1-6 months.

What needs of a minority and/or handicapped population does this program meet and how?

1. Facility accessible to physically disabled (does not meet 504 regulation).
2. Limited bilingual (Spanish) capability.
3. Availability of interpreter for hearing-impaired client.

What unique need does this program meet? It is the only mental health outpatient program offering mental health services to the low income with acute and chronic emotional disturbance.

Is your program designed to meet the mental health needs of any County's minority population? Due to staff reduction, this program utilizes the Children & Youth Services' Spanish-speaking psychologist to provide community consultation and direct services to the Spanish-speaking population, which constitutes the major minority population in the area served.

CENTRAL OAKLAND DAY TREATMENT - 0120

Partial Day Care

	1977-78 Past Year Actual	1978-79 Estimated Current Year	1979-80 Estimated Budget Year
Unduplicated Clients Served Per Year	DATA NOT AVAILABLE		
Program Cost	D 207,184 I 8,051 Total 215,235	187,265 5,228 192,493	240,149 12,039 252,188
% of Total County M.H. Budget	9	8	1.0
Units of Service	D 5,147 I 297	5,425 275	3,566 385

DEMOGRAPHIC CHARACTERISTIC (1970 CENSUS) OF AREA SERVED

	Number	% of Area	% of Discharge from service site
Indian	1,109	0.6	3.3
Black	54,483	28.7	16.7
Chinese	7,091	3.7	5.0
Filipino	1,527	0.8	0
Japanese	1,469	0.8	0
Spanish	12,214	6.4	8.3
White	110,327	58.2	65.0
Other	1,021	0.5	1.7

DATA FOR 1979/80

Age Group Treated: 18-65+

Target Group(s): MD

Primary Problems Treated: Severely emotionally disturbed persons who are experiencing psychiatric disturbances, such patients usually had the onset of problems five years ago or more, and often have a history of more than four hospitalizations. Aggressive follow-up and utilization of a wide range of treatment modalities in order to prevent rehospitalization are required.

CENTRAL OAKLAND DAY TREATMENT - 0120

Program Objectives: To maintain an average monthly caseload of 80. To provide a group treatment modality to enable patients to move toward greater independence. To maintain close liaison with other community services, such as psychiatric inpatient facilities, half-way houses, the sub-acute facility and private practitioners. To establish close linkage with existing pre-vocational and vocational training programs and to develop our own using community resources.

Estimated Average Duration of Treatment: 12 months

What needs of a minority and/or handicapped population does this program meet and how? Staffing pattern permits the provision of services to all English-speaking persons of any ethnic group. Close liaison with the Asian Mental Health Program permits the provision of services to Asian clients and their families. Liaison with Spanish-speaking personnel at Central Oakland Community Mental Health Center also permits the provision of services to Spanish-speaking clients and families. Limited accessibility to physically disabled.

What unique need does this program meet? Clients are taken into this program who are not likely to make significant gains in the relatively brief course of therapy as provided in the Acute Day Treatment Program. This program provides longer-term, structured, goal-oriented program, which can be tailored to meet the individual needs of each client.

Is your program designed to meet the mental health needs of any county's minority population? See above.

CENTRAL OAKLAND ADULT OUTPATIENT SERVICE - 0101

Outpatient Care

	1977-78 Past Year Actual	1978-79 Estimated Current Year	1979-80 Estimated Budget Year
Unduplicated Clients Served Per Year	DATA	NOT AVAILABLE	
Program Cost	D 424,785 I 86,252 Total 511,037	449,622 73,874 523,496	556,335 132,779 689,114
% of Total County M.H. Budget	2.0	2.0	2.6
Units of Service	D 8,788 I 1,471	8,329 1,140	9,170 1,946

Figures include Asian Program

DEMOGRAPHIC CHARACTERISTIC (1970 CENSUS) OF AREA SERVED

	Number	% of Area	% of Discharge ** from service site
Indian	1,109	0.6	3.3
Black	54,483	28.7	16.7
Chinese	7,091	3.7	5.0
Filipino	1,527	0.8	0
Japanese	1,469	0.8	0
Spanish	12,214	6.4	8.3
White	110,327	58.2	65.0
Other	1,021	0.5	1.7

DATA FOR 1979/80

Age Group Treated: 18-65+

Target Group(s): MD

**Data obtained from Services Assessment Summary Report, based on 7/1/77 to 6/30/78 discharges

CENTRAL OAKLAND ADULT OUTPATIENT SERVICE - 0101

Primary Problems Treated:

1. Adults who have a history of hospitalization at either state, local, public or private facilities.
2. Adults never hospitalized but at risk of requiring such care if they do not receive services.
3. Persons experiencing a life crisis.

Program Objectives:

1. Increase community awareness of the center's programs through development/distribution of a brochure describing services provided and broadening contacts with catchment area groups, organizations and agencies.
2. Increase monthly caseload to 375 and provide 9100 units of direct service.
3. Increase coordination with North Region County-operated and contract mental health centers.
4. Provide 1500 hours of community services.
5. Participate in the development and implementation of a County-wide plan of service to Residential Care Facilities.
6. Develop a program design for providing consultation services.
7. Explore the need for consultation with the Oakland Housing Authority and Travelers' Aid.

Estimated Average Duration of Treatment: 8 months

What needs of a minority and/or handicapped population does this program meet and how? Staffing pattern permits the provision of culturally relevant services to the following ethnic groups: Black, Spanish, White. Linkages and consultation with Asian Mental Health Unit, Intertribal Friendship House and International House is used to provide service capability to Asian residents and very minimally to Native American and other ethnic groups. Services are not targeted to physically handicapped persons. However, the service site facility is accessible to handicapped persons who, among other abilities, have use of hands and sight. Also, there is one person on staff with sign language capability.

What unique need does this program meet? Outpatient psychiatric and community services are provided to the severely disturbed, poor, elderly, isolated and ethnic minority persons who comprise the population of the catchment area who would not likely be served elsewhere.

Is your program designed to meet the mental health needs of any county's minority population? See above.

WEST OAKLAND DAY TREATMENT - 0170

Partial Day Care

	1977-78 Past Year Actual	1978-79 Estimated Current Year	1979-80 Estimated Budget Year
Unduplicated Clients Served Per Year	DATA NOT AVAILABLE		
Program Cost	D 153,987 I Total 153,987	151,783 151,783	175,799 175,799
% of Total County M.H. Budget	.6	.6	.6
Units of Service	2,970	2,755	2,755

DATA FOR 1979/80

Age Group Treated: 0-65+

Target Group(s): MD

Primary Problems Treated: Persons with acute mental illness at risk of psychiatric hospitalization.

Program Objectives: To provide a structured treatment program which:

1. Reduce need to hospitalize those patients who are most at risk.
2. Return individuals to the community and restores social functioning.
3. Facilitates transition from hospitalization to self-sufficiency.

Estimated Average Duration of Treatment: 5 months

What needs of a minority and/or handicapped population does this program meet and how? Provides physically and culturally accessible day treatment services in an area whose population is predominantly black and which is at high risk of psychiatric hospitalization.

What unique need does this program meet? Provides physically and culturally accessible partial day care services in a high risk (of inpatient hospitalization) area.

How is your program designed to meet the mental health needs of any county's minority population? This program is owned, operated by representatives of the minority population it serves, i.e. primarily black.

WEST OAKLAND HEALTH CENTER - 0170

Outpatient and Rehabilitation Services

	1977-78 Past Year Actual	1978-79 Estimated Current Year	1979-80 Estimated Budget Year
Unduplicated Clients Served Per Year	DATA NOT AVAILABLE		
Program Cost	D 393,149 I Total 393,149	357,103 357,103	334,033 334,033
% of Total County M.H. Budget	1.6	1.4	1.3
Units of Service	8,095	5,744	5,744 visits

DATA FOR 1979/80

Age Group Treated: 18-65+

Target Group(s): MD

Primary Problems Treated: Depressive and anxiety reaction; acute and chronic schizophrenia. Individuals, couples or families experiencing a life crisis; individuals with neurotic dysfunction that has severely impaired the individual's capacity to function effectively; individuals who are or have been psychotic and may be experiencing a recurrence of symptoms; individuals who have a history of frequent or lengthy hospitalization and require long-term supportive psychiatric treatment to avoid further psychiatric hospitalization.

Program Objectives: To provide a comprehensive program of mental health outpatient services which is relevant and geared to the needs of the residents of Northwest Oakland and Emeryville target area; including crisis intervention, outpatient short- and long-term therapy, resocialization, information and referral, and mental health consultaton/education services.

Estimated Average Duration of Treatment: Crisis: 1 month; Outpatient: 4 months.

What needs of a minority and/or handicapped population does this program meet and how? Provides physically and culturally accessible outpatient mental health services in an area whose population is predominantly black and which is at high risk of acute mental illness.

What unique need does this program meet? Provides physically and culturally accessible crisis/outpatient and rehabilitation services in an area of high risk.

WEST OAKLAND HEALTH CENTER - 0170

How is your program designed to meet the mental health needs of any County's minority population? This program is owned and operated by representatives of the minority population it serves, i.e. primarily black.

Outpatient Care

	1977-78 Past Year Actual	1978-79 Estimated Current Year	1979-80 Estimated Budget Year
Unduplicated Clients Served Per Year	DATA NOT AVAILABLE		
Program Cost	D 181,194 I 14,326 Total 195,520	152,983 10,755 163,738	173,468 24,271 197,739
% of Total County M.H. Budget	.8	.6	.8
Units of Service	D 3,135 I 176	3,660 177	3,714 379

DEMOGRAPHIC CHARACTERISTIC (1970 CENSUS) OF AREA SERVED

	Number	% of Area	% of Discharge from service site
Indian	10	.5	0
Black	1,924	2.6	4.9
Chinese			
Filipino	4,155	5.6	1.2
Japanese			
Spanish	7,342	9.8	3.7
White	60,310	81.5	90.2
Other			
	74,000	100.0%	100.0%

DATA FOR 1979/80

Age Group Treated: 18-65+

Target Group(s): MD

Primary Problems Treated: Mental illness and emotional disturbances in adults. Priority patients are those referred from Highland Psychiatric Inpatient Services, Laurel House, Napa, Highland Psychiatric Emergency

Service, private psychiatric hospitals and the Alameda Hospital Emergency Room. Any person in need of crisis intervention for reasons of suicidal risk, life crises or pre-psychotic condition. Persons who by reason of disturbed behavior have become involved with law enforcement, e.g. child abusers, rapists, wife beaters, etc. Classes of persons who fall into "at risk" categories such as single parents, the elderly loner, the alienated young adult.

Program Objectives: Provide outpatient treatment to adults at risk of hospitalization to avoid hospitalization. Provide follow-up continuing care for post-hospitalized adults to prevent decompensation and rehospitalization. Provide crisis intervention for adults in danger to self and/or others. Linking gravely disabled persons wih public and private services for health, shelter, and sustenance.

Estimated Average Duration of Treatment: Crisis 2-3 months; Rehabilitation 6-12 months.

What needs of a minority and/or handicapped population does this program meet and how? In the context of providing services to the mentally disordered, the needs of the minority and/or handicapped populations are met as fully as possible by having ethnically relevant and sensitive staff. Accessible services, linking for special services, and advocating for these groups with agencies and in the community. Caseload in 1978-79 comprised 11% Spanish surname, 10% Black, and 2% Asian.

What unique need does this program meet? This program services the needs of mentally ill population of Catchment Area 19/Alameda. Public Health and Mental Health collaboration in working with mentally ill. Outreach to population at risk.

Is your program designed to meet the mental health needs of any county's minority population? Hiring of minority staff such as Black and Filipino. Having staff with language skills (Spanish/Tagalog) makes the service culturally accessible. Education for all staff regarding minority and ethnic concerns linkages with culturally relevant services such as Asian Mental Health, El Centro and East Oakland Health Alliance.

GLADMAN MEMORIAL HOSPITAL - 0180

24-Hour Care

	1977-78 Past Year Actual		1978-79 Estimated Current Year	1979-80 Estimated Budget Year
Unduplicated Clients Served Per Year	DATA NOT AVAILABLE			
Program Cost	D	$336,508	$365,000	N/A
	I			
	Total	$336,508	$365,000	
% of Total County M.H. Budget	1.3		1.4	N/A
Units of Service	D	1,608	1,738	N/A
	I			

Note: State Funds have not been made available as of this date to continue utilization of the ten acute Inpatient beds at this facility in 1979-80.

Partial Day Care

	1977-78 Past Year Actual	1978-79 Estimated Current Year	1979-80 Estimated Budget Year
Unduplicated Clients Served Per Year	DATA NOT	AVAILABLE	
Program Cost	D 176,309 I Total 176,309	180,456 180,456	189,389 189,389
% of Total County M.H. Budget	.7	.7	.7
Units of Service	5,363	3,308	3,308

DEMOGRAPHIC CHARACTERISTIC (1970 CENSUS) OF AREA SERVED

	Number	% of Area	% of Discharge from service site
Indian	1,856	1.0	0
Black	68,312	36.8	38.6
Chinese	4,455	2.4	4.3
Filipino	2,042	1.1	0
Japanese	928	0.5	0
Spanish	24,503	13.2	5.7
White	81,120	43.7	50.0
Other	2,413	1.3	1.4

DATA FOR 1979/80

Age Group Treated: 18-64

Target Group(s): MD

Primary Problems Treated: Acute mental disorders such as schizophrenia, depression, and manic-depressive illness which would require patients to be hospitalized if appropriate therapeutic interventions were not available.

Program Objectives: To provide treatment for a daily average census of 30 patients, in order to avoid or minimize hospitalization and facilitate an earlier return to the community, job, or home.

Estimated Average Duration of Treatment: 3 months.

What needs of a minority and/or handicapped population does this program meet and how? This program meets the needs of the target population, which includes minority and handicapped persons, for a partial hospitalization service which is accessible and sensitive to the unique cultural and physical needs of minority and handicapped persons. Staff is representative of the minority composition of the community.

What unique need does this program meet? This program permits seriously mentally ill people to be treated in their own community in a five-day-a-week psychotherapeutic milieu as an alternative to local or state hospitalization.

Is your program designed to meet the mental health needs of any county's minority population? The program is located in a predominantly minority community, is easily accessible on public transportation to all residents of the catchment area. In addition, about one half of the patients are from minority groups and their needs are considered in designing and staffing the services.

EAST OAKLAND COMMUNITY MENTAL HEALTH CENTER - ADULT - 0108

Outpatient Care

	1977-78 Past Year Actual	1978-79 Estimated Current Year	1979-80 Estimated Budget Year
Unduplicated Clients Served Per Year	DATA NOT AVAILABLE		
Program Cost	D 689,687 I 177,657 Total 867,344	954,373 156,658 1,111,031	1,087,497 261,894 1,349,341
% of Total County M.H. Budget	3.5	4.3	5.2
Units of Service	D 16,808 I 3,081	17,541 2,838	18,446 3,145

DEMOGRAPHIC CHARACTERISTIC (1970 CENSUS) OF AREA SERVED

	Number	% of Area	% of Discharge from service site
Indian	1,856	1.0	1.4
Black	68,312	36.8	61.3
Chinese	4,455	2.4	0.4
Filipino	2,042	1.1	.7
Japanese	928	0.5	0.4
Spanish	24,503	13.2	4.6
White	81,120	43.7	30.6
Other	2,413	1.3	0.6

DATA FOR 1979/80

Age Group Treated: 18-65+

Target Group(s): MD

Primary Problems Treated: The Center's highest priority patients are those adults with histories of psychiatric hospitalizations or those at risk of requiring such care if they do not receive mental health services.

EAST OAKLAND COMMUNITY MENTAL HEALTH CENTER - ADULT - 0108

Program Objectives:

1. Provide outpatient treatment to adults at risk of hospitalization.
2. Provide continuing care for post-hospitalized adults to prevent decompensation and rehospitalization.
3. Provide crisis intervention for adults who are of danger to self or others, or gravely disabled.
4. Link gravely disabled persons with public and private services for health, shelter and sustenance.
5. Participate in Agency mechanisms to maintain and improve quality of services.
6. Develop plans for continuity of funding.

Estimated Average Duration of Treatment: 0-6 months, 52%; 6 months-1 year, 14%; 1-2 years, 18%, 2+ years, 16%.

What needs of a minority and/or handicapped population does this program meet and how? This program meets the needs of minority and handicapped populations for accessible and culturally sensitive psychiatric outpatient services. As noted above, 69.4% of services are to patients from minority groups.

What unique need does this program meet? Outpatient psychiatric services to all ethnic groups in East Oakland.

Is your program designed to meet the mental health needs of any county's minority population? Yes. The services are provided out of a shopping center complex which is easily accessible to the target population, which includes many patients from minority groups. In addition, 67% of the staff have been recruited from minority groups. The entire program emphasizes accessibility and sensitivity to minority patients.

ASIAN COMMUNITY MENTAL HEALTH SERVICE - 0101

Outpatient Care

	1977-78 Past Year Actual	1978-79 Estimated Current Year	1979-80 Estimated Budget Year
Unduplicated Clients Served Per Year	*		
Program Cost	D I Total		
% of Total County M.H. Budget			
Units of Service			

DEMOGRAPHIC CHARACTERISTIC (1970 CENSUS) OF AREA SERVED

	Number	% of Area	% of Discharge from service site
Indian			
Black			
Chinese		2.8	
Filipino		1.3	
Japanese		0.7	
Spanish			
White			
Other		0.8	
Korean		0.1	

DATA FOR 1979/80

Age Group Treated: 18-65+

Target Group(s): MD

Primary Problems Treated: Chronically mentally disordered.

*Please refer to Central Oakland Adult Outpatient Service, 0101

ASIAN COMMUNITY MENTAL HEALTH SERVICE - 0101

Program Objectives: To make County Mental Health Services accessible, available to the Asian population.

Estimated average duration of treatment: 1-2 years

What needs of a minority and/or handicapped population does this program meet and how? Meeting the needs of Asian minority for direct mental health services through bilingual/bicultural staff with a model emphasizing outreach, family therapy, linkage with resources and concrete problem solving.

What unique need does this program meet? Ability to serve the bilingual/bicultural segment of the Asian population.

Is your program designed to meet the mental health needs of any county's minority population? Yes, the Asian population.

CRIMINAL JUSTICE MENTAL HEALTH PROGRAM - 0112

Outpatient Care

	1977-78 Past Year Actual	1978-79 Estimated Current Year	1979-80 Estimated Budget Year
Unduplicated Clients Served Per Year	Data Unavailable	Data Unavailable	Data Unavailable
Program Cost	D 465,847 I Total 465,847	433,719 433,719	375,034 375,034
% of Total County M.H. Budget	1.9	1.7	1.4
Units of Service	5,206	5,382	4,935

DATA FOR 1979/80

Age Group Treated: 18-65+

Target Group(s): MDO

Primary Problems Treated: The population served is that of mentally ill offenders in custody.

Program Objectives: To continue to provide one hundred 4011.6 PC initial diagnostic evaluation interviews and reports per month. To continue to provide 300 4011.8 PC follow-up counseling and treatment interviews per month. To continue to provide six Probation-referred Court dispositional recommendations (per AB 1229) per month. To continue to maintain liaison with the Criminal Justice Inpatient Unit at Highland Hospital, with the medical unit at Santa Rita Jail, and with the unit administered by the Office of Continuing Care of the State Department of Health for follow-up of AB 1229 placements in the community.

Estimated Average Duration of Treatment: Emergency Service opens and closes a case at each visit.

What Needs of a Minority and/or Handicapped Population Does this Program Meet and How? Since minority group members make up a disproportionately large share of the jail population in Alameda County, the majority of the clinic's patients are minority group members. Criminal Justice Mental Health Program, since its inception, has pursued an affirmative action hiring policy.

What Unique Need Does this Program Meet? The mental health needs of the mentally ill person in custody in the penal system.

How is Your Program Designed to Meet the Mental Health Needs of any County's Minority Population? See above.

CRIMINAL JUSTICE MENTAL HEALTH-AB1229 COMPONENT - G112

Outpatient Care

	1977-78 Past Year Actual	1978-79 Estimated Current Year	1979-80 Estimated Budget Year
Unduplicated Clients Served Per Year	DATA NOT AVAILABLE		
Program Cost	D I Total N/A	105,291*	112,012
% of Total County M.H. Budget	N/A	.4	.4
Units of Service	N/A		339

DATA FOR L979/80

Age Group Treated: 18-65+

Target Group(s): MDO

Primary Problems Treated: Patients determined to be: (1) Incompetent to stand trial (per 1368 PC), (2) Insane (per 1026 PC), or a (3) Mentally Disordered Sex Offender.

Program Objectives: To continue to evaluate for disposition up to 50 forensic mental health commitments per year referred by the court at the time of commitment. To continue to evaluate for transfer to outpatient status up to 40 forensic mental health patients referred by the state hospitals. To continue to supervise, through the contract with the Office of Continuing Care, up to 30 forensic patients on outpatient status.

Estimated Average Duration of Treatment: The Criminal Justice Mental Health AB-1229 component is an evaluation unit, not a treatment unit. Those outpatients supervised by the Office of Continuing Care will be treated in the community for approximately one year.

What needs of a minority and/or handicapped population does this program meet and how? (1) Facility accessible to physically disabled, (2) Minority staffing, and (3) Availability of interpreter for hearing-impaired clients.

What unique need does this program meet? (1) The mental health needs of those

*This cost is not included in the 9/1/78 CR/DC; however, it will be reflected in the revised 9/1 CR/DC budget.

patients on forensic mental health commitments, and (2) The needs of the courts for psychiatric commentary to ensure informed decisions about this special population.

How is your program designed to meet the mental health needs of any county's minority population? See above.

MENTAL HEALTH VOCATIONAL PROGRAM - 0112

Outpatient Care

	1977-78 Past Year Actual	1978-79 Estimated Current Year	1979-80 Estimated Budget Year
Unduplicated Clients Served Per Year	n/a	n/a	n/a
Program Cost	D 267,713 I Total 267,713	210,591 210,591	285,271 285,271
% of Total County M.H. Budget	1.1	.8	1.1
Units of Service	4,566	5,472	4,346

DEMOGRAPHIC CHARACTERISTIC (1970 CENSUS) OF AREA SERVED

	Number	% of Area	% of Discharge from service site
Indian	997	.41	0
Black	2,056	.84	7
Chinese	4,825	1.96	1
Filipino	Included in "Other"		
Japanese	Included in "Asian" (Chinese)		
Spanish	42,095	17.11	16
White	193,701	78.75	73
Other	2,285	.93	3
	245,959	100.00	100

DATA FOR 1979/80

Age Group Treated: 18-65+

Target Group(s): MD, DD, DA

Primary Problems Treated: This program deals exclusively with the vocational rehabilitation of the mentally handicapped. Primary problems treated: absence of job skills, poor work habits, lack of self-confidence, lack of work experience.

MENTAL HEALTH VOCATIONAL PROGRAM - 0112

Program Objectives: (A) Provide work experience and classroom training for 60 CETA funded clients. (B) Provide work adjustment and job skill training for 25 Sheltered Workshop clients.

Estimated Average Duration of Treatment: Nine months.

What Needs of a Minority and/or Handicapped Population Does this Program Meet and How? The CETA grant which funds the bulk of our program contractually obligates the enrollment of clients based on the ethnic distribution present in the community. All of the clients served in our program are mentally handicapped. Additionally, our program is accessible to clients who have additional handicaps such as physical disability, developmental disability, and drug or alcohol disability.

What Unique Need Does this Program Meet? This is the only comprehensive vocational rehabilitation program for the mentally handicapped in this community.

Is Your Program Designed to Meet the Mental Health Needs of any County's Minority Population? See above response.

BERKELEY-ALBANY CRISIS INTERVENTION -0197

Outpatient Care

	1977-78 Past Year Actual	1978-79 Estimated Current Year	1979-80 Estimated Budget Year
Unduplicated Clients Served Per Year	DATA NOT AVAILABLE		
Program Cost	D I Total 150,426	136,560	130,577
% of Total County M.H. Budget	.6	.5	.5
Units of Service	2,265	2,200	2,200

DATA FOR 1979/80

Age Group Treated:*

Target Group(s):*

Primary Problems Treated:*

Program Objectives:*

Estimated Average Duration of Treatment:*

What needs of a minority and/or handicapped population does this program meet and how?*

What unique need does this program meet?*

Is your program designed to meet the mental health needs of any county's minority population?*

*Please refer to City of Berkeley, Short-Doyle Plan, 1979/80

BERKELEY-ALBANY DAY TREATMENT - 0197

Partial Day Care

	1977-78 Past Year Actual	1978-79 Estimated Current Year	1979-80 Estimated Budget Year
Unduplicated Clients Served Per Year	DATA NOT AVAILABLE		
Program Cost	D I Total 139,567	127,170	128,861
% of Total County M.H. Budget	.6	.5	.5
Units of Service	2,063	2,000	2,000

DATA FOR 1979/80

Age Group Treated:*

Target Group(s):*

Primary Problems Treated:*

Program Objectives:*

Estimated Average Duration of Treatment:*

What needs of a minority and/or handicapped population does this program meet and how?*

What unique need does this program meet?*

Is your program designed to meet the mental health needs of any county's minority population?*

*Please refer to City of Berkeley, Short-Doyle Plan, 1979/80

BERKELEY-ALBANY REHABILITATION - 0197

Outpatient Care

	1977-78 Past Year Actual	1978-79 Estimated Current Year	1979-80 Estimated Budget Year
Unduplicated Clients Served Per Year	DATA NOT AVAILABLE		
Program Cost	D I Total 143,395	154,690	155,131
% of Total County M.H. Budget	.6	.6	.6
Units of Service	1,947	2,500	2,500

DATA FOR 1979/80

Age Group Treated:*

Target Group(s):*

Primary Problems Treated:*

Program Objectives:*

Estimated Average Duration of Treatment:*

What needs of a minority and/or handicapped population does this program meet and how?*

What unique need does this program meet?*

Is your program designed to meet the mental health needs of any county's minority population?*

*Please refer to City of Berkeley, Short-Doyle Plan, 1979/80

EL CENTRO DE SALUD MENTAL - 0191

Consultation, Education and Information

	1977-78 Past Year Actual	1978-79 Estimated Current Year	1979-80 Estimated Budget Year
Unduplicated Clients Served Per Year	DATA NOT AVAILABLE		
Program Cost	SD 102,122 NIMH 53,548 Total 155,670	102,129 53,691 155,820	107,235 54,064 161,299
% of Total County M.H. Budget	.4 .2	.4 .2	.4 .2
Units of Service	SD 7,703 NIMH 5,334	7,703 5,334	7,703 5,334

DATA FOR 1979/80

Age Group Treated: 0-65+

Target Group(s): MD

Primary Problems Treated: Outreach to the North Region Spanish-speaking population in need of mental health services. Primary prevention services directed toward specifically identified, vulnerable, high-risk groups within the community who have not yet been labeled as psychiatrically ill. To encourage measures to be taken to avoid emotional disturbances and promote positive well being in the daily lives of this minority population.

Program Objectives:

1. Consultation: to provide technical assistance by direct contact. Sharing skills, knowledge and training with allied professionals and community care givers. Problem solving, increasing mental health skills, and improving the capability of the allied care givers or their agencies.

2. Education: to provide knowledge of the principles of sound personal and community mental health through direct contact with agencies, community groups and individuals or groups of individuals not identified as patients.

3. Information: to provide information by directly contacting agencies, community groups, and individuals not identified as clients. Information provided is about mental health services, their location, types of services, referral channels, changes in programs, and significant legislation. Also

included are indirect contacts with the general public through literature and the mass media regarding mental health and mental disorders.

4. Community organizations: involvement in projects to enhance the planning and development of programs which have broad impact upon the community.

5. Community client advocacy: provide person to person assistance in problem-solving, or improving the health and well-being of an individual who is not a designated client and does not receive a diagnosis.

Estimated Average Duration of Treatment: 4-5 months

What needs of a minority and/or handicapped population does this program meet and how? El Centro provides bilingual/bicultural Spanish outpatient mental health services to Northern Alameda County's Spanish speaking population. Emphases is placed on continual development of educational and innovative approaches most sensitive to addressing community mental health needs and effective in resolving presenting mental health problems. (Compounding the problem of unavailability of mental health services to the Raza population, is this community's negative perception of existing public mental health services).

What unique need does this program meet? See above.

How is your program designed to meet the mental health needs of any county's minority population? See "Needs of a minority and/or handicapped population".

LA FAMILIA COUNSELING SERVICE - 0105

Consultation, Eduation and Information

	1977-78 Past Year Actual	1978-79 Estimated Current Year	1979-80 Estimated Budget Year
Unduplicated Clients Served Per Year	DATA NOT AVAILABLE		
Program Cost	D I Total 82,764	102,667	107,800
% of Total County M.H. Budget	.3	.4	.4
Units of Service	2,091	1,900	1,900

DATA FOR 1979/80

Age Group Treated: 0-65+

Target Group(s): MD

Primary Problems Treated: Raza needs in education, information, advocacy, life crisis, problems solving and environmental/institutional related problems.

Program Objectives: To provide individual, group, family assessment-intervention and education. To provide consultation/education and liaison services. To provide planning and preparation hours for consultation, education and liaison services; education, information and advocacy services. To provide psychotherapy sessions through other funding sources.

Estimated Average Duration of Treatment: Short-term treatment on average is three months. On long-term treatment treatment, an average is one year.

What needs of a minority and/or handicapped population does this program meet and how? La Familia m-ets the needs of Raza population in Southern Alameda County who are bilingual/bicultural and those who are monolingual Spanish-speaking. The mental health needs are provided by a bilingual/bicultural staff trained to provide consultation, education and information about mental health in a culturally relevant manner.

What unique need does this program meet? La Familia meets the unique need of a bilingual/bicultural mental health clinic in Southern Alameda County where as yet there is no other such needed service in existence.

How is your program designed to meet the mental health needs of any county's minority population? La Familia is staffed by Raza-bilingual-bicultural mental health professionals trained to meet the mental health needs of the people in the community in a relevant manner.

ASIAN COMMUNITY MENTAL HEALTH BOARD, INC. - 0163

Consultation, Education and Information

	1977-78 Past Year Actual	1978-79 Estimated Current Year	1979-80 Estimated Budget Year
Unduplicated Clients Served Per Year	N/A	N/A	N/A
Program Cost	D I 150,257 Total 150,257	148,284 148,284	151,289 151,289
% of Total County M.H. Budget	.6	.6	.6
Units of Service	13,033	13,033	13,033

DATA FOR 1979/80

Age Group Treated: 0-65+

Target Group(s): MD, DD (without exclusion of other groups)

Primary Problems Treated:

1. Cultural adjustment of new Asian immigrants.
2. Family and marital problems among Asian immigrant families.
3. Lack of sensitivity and knowledge among service providers to mental health needs of Asians.
4. Lack of knowledge and awareness of mental health issues within Asian communities.

Program Objectives:

1. To enhance skills of mental health service providers in agencies serving Asian communities in Alameda County, through consultation services.
2. To enable individuals and groups in the Asian communities to better cope with stress and develop positive attitudes towards mental health through community education programs and brief counseling.
3. To provide information and referral to appropriate mental health resources.
4. To initiate, develop and advocate for programs/services for the Asian communities.
5. To train students and volunteers in relevant mental health services delivery to Asian clients.
6. To conduct evaluative research and assessments for effective planning of programs for the Asian communities.

Estimated Average Duration of Treatment: Ranges from single contact to ongoing contact for several months.

What needs of a minority and/or handicapped population does this program meet and how? The program provides accessible mental health services to four minority Asian communities through 1) outreach and advocacy by bilingual/bicultural workers, 2) education programs in the community, 3) a community board reflective of the population.

What unique need does this program meet? The program is designed to enable the Asian communities to utilize mental health services. The need for education with follow-up services that are accessible is being met through a variety of services.

How is your program designed to meet the mental health needs of any county's minority population? This program is specifically designed through staffing and cultural sensitivity to respond to the needs of the major Asian groups in Alameda County.

EAST OAKLAND HEALTH ALLIANCE - ADULT - 0190

Outpatient Care and C.E. and I.

	1977-78 Past Year Actual	1978-79 Estimated Current Year	1979-80 Estimated Budget Year
Unduplicated Clients Served Per Year	DATA NOT AVAILABLE		
Program Cost	D 102,824 I 51,596 Total 154,420	120,271 51,545 171,816	125,957 54,122 180,079
% of Total County M.H. Budget	.6	.7	.7
Units of Service	D 2,181 I 0	2,475 1,650	2,475 1,650

DATA FOR 1979/80

Age Group Treated: 18-65+

Target Group(s): MD

Primary Problems Treated: Neurosis, life crisis, learning disabilities, psychosis and situational disturbances.

Program Objectives:

1. To provide crisis and brief treatment mental health services to residents of Catchment 20. (East Oakland) Adult services.
2. To provide adult and consultation, education and information services to community agencies and groups concerning Mental Health issues and direct service problems in the community.

Estimated Average Duration of Treatment: 3-6 months

What needs of a minority and/or handicapped population does this program meet and how? Provides curturally oriented (primarily black) psychotherapeutic services including group, individual, family therapy. Provide counseling groups for teenagers, parents, families and adolescent parents.

What unique need does this program meet? A community-based outpatient mental health program accessible to the East Oakland community.

How is your program designed to meet the mental health needs of any county's minority population? Cultural sensitivity provided by location in minority community, staff reflecting ethnic minority population of community (primarily black), outreach and transportation services offered and culturally oriented therapeutic services provided.

SUICIDE PREVENTION - 0185

Consultation, Education and Information

	1977-78 Past Year Actual	1978-79 Estimated Current Year	1979-80 Estimated Budget Year
Unduplicated Clients Served Per Year	N/A	N/A	N/A
Program Cost	D 76,190 I Total 76,190	74,974 74,974	78,723 78,723
% of Total County M.H. Budget	.3	.3	.3
Units of Service	8,520	8,520	8,520

DATA FOR 1979/80

Age Group Treated: 18-65+

Target Group(s): MD

Primary Problems Treated: Suicide and other impulse control issues. Community maintenance of mentally ill.

Program Objectives:

1. Provide a free and confidential volunteer-based, 24-hour a day emergency counseling and aid service.
2. Provide primary prevention through targeted educational and training programs.
3. Train volunteers to a standard of high competence.

Estimated Average Duration of Treatment: Typically, a person will stay in contact with us for several months with a mean range of 4 to 10 calls. Ranges from one contact to hundreds over a period of years.

What needs of a minority and/or handicapped population does this program meet and how? Reliance on communication by telephone makes this program ideal for persons with handicaps affecting mobility or sight. Handicapped persons often suffer from isolation due to immobility, and volunteers assist handicapped people during periods of stress and crisis. Limited bilingual capability exists among staff and volunteers but no 24-hour capability. Interpreters are available to phone back clients who don't speak English. Access for wheelchairs is not applicable because clients do not come to facility. No capability to deal with deaf clients on phone currently exists.

What unique need does this program meet?

SUICIDE PREVENTION - 0185

The suicide rate in Alameda County ranges from 50% to 100% above the national average. This unique volunteer program is the only effort directed towards this problem.

How is your program designed to meet the mental health needs of any county's minority population? Program has liaisons with El Centro and International Institute to provide bilingual call-back service. A specialized referral list of public and private minority agencies is maintained and continually updated.

OFFICE OF CONTINUING CARE - 0090

Outpatient Care

	1977-78 Past Year Actual	1978-79 Estimated Current Year	1979-80 Estimated Budget Year
Unduplicated Clients Served Per Year	DATA NOT AVAILABLE		
Program Cost	D I Total 1,001,532	840,029	
% of Total County M.H. Budget	4.3	3.2	
Units of Service	2,600	2,600	

DATA FOR 1979/80

Age Group Treated: 18-65+

Target Group(s): MD

Primary Problems Treated: All mentally disabled persons whose problems fall under TITLE XX regulations.

Program Objectives: The goals of the Office of Continuing Care must conform to Title XX guidelines and are the reduction or prevention of dependency and reduction or prevention of inappropriate institutional care. The present Office of Continuing Care is under contract to the county and provides the following services: Consultation to 164 board and care homes out of a county-wide total of 244. Direct services to 389 residents of 2454. Direct services to 244 clients countywide in independent living, assist or direct Creative Living Center programs in conjunction with the Social Services Bureau and the Regional Mental Health Services. Placement out of 24-hour facilities.

Estimated Average Duration of Treatment: No limit

What unique need does this program meet? Services are focused toward adults who have a history of repeated psychiatric hospitalizations or chronic mental disorder, or who are at risk of developing such chronicity. Emphasis is placed on persons being discharged from state and local psychiatric hospitals and those who, without such services, would require hospitalization.

DEPARTMENT OF VOCATIONAL REHABILITATION* - 0165

OUTPATIENT CARE

	1977-78 Past Year Actual	1978-79 Estimated Current Year	1979-80 Estimated Budget Year
Unduplicated Clients Served Per Year	N/A	N/A	N/A
Program Cost	D I Total $375,913	N/A	N/A
% of Total County M.H. Budget	1.5%	N/A	N/A
Units of Service	N/A	N/A	N/A

* Contract terminated as of June, 1978.

Transitional Residential Treatment

	1977-78 Past Year Actual	1978-79 Estimated Current Year	1979-80 Estimated Budget Year
Unduplicated Clients Served Per Year	N/A	N/A	N/A
Program Cost	D (Adm I &CLC) 184,328 Total CC 11,344	Adm. 61,771 CLC 126,694 CC 11,344	Adm. 62,957 CLC 127,731 CC 11,911
% of Total County M.H. Budget	.7 .1	.2 .5 .1	.2 .5 .1
Units of Service	Adm & CLC 3,488 CC 1,750	Adm. 3,488 CLC 3,488 CC 1,078	Adm. 3,488 CLC 3,488 CC 1,078

Age Group Treated: 18-64 (16-17 served with letter of permission from guardian)

Target Group(s): MD

Primary Problems Treated:

1. Psychotic sympomatology (e.g. ambivalence, paranoid ideation).
2. Depression, social isolation and withdrawal.
3. Anti-social behavior (e.g. combativeness and/or threatening behavior).
4. Suicidal acting out or threats of suicide.
5. Lack of communication skills and/or difficulty with interpersonal relationships.
6. Inadequate problem-solving skills.

Program Objectives:

1. To minimize or avert the use of the psychiatric hospital and reduce length of stay if re-hospitalized.
2. To facilitate the client's progress toward highest possible level of self sufficiency.
3. To enable the client to live in the least restrictive possible setting that meets his/her psychosocial needs.
4. To involve each resident within 30 days of entry into the facility, in a full daytime activity which will facilitate independence upon planned discharge.

Adm. = Administration, CLC = Creative Living Center, CC = Continuing Care Funding

5. To develop a written goal plan with each resident within 30 days of entry into the facility which will be periodically re-assessed and modified.
6. To develop within at least 75% of the planned discharge residents demonstrable basic living skills necessary for independent living (i.e., budgeting, shopping, cooking, cleaning, personal hygiene), through planned daily activities in the milieu setting and individual instruction.
7. To link each resident who remains over 30 days to at least one public or private rehabilitative service which will be used while in residency and continued after discharge.
8. To develop a plan for discharge with each resident in the final phase prior to discharge, including such necessary areas as housing and linkage with community support services.

Estimated Duration of Treatment: 6 months

What needs of a minority and/or handicapped population does this program meet and how? This Transitional Residential Treatment Facility serves all residents of Alameda county and attempts to maintain a balance among the residents which is reflective of the ethnic and cultural diversity of the population of the County, served by an integrated and some bilingual staff.

What unique need does this program meet? This program meets the client's need for a residential treatment facility which offers a comprehensive rehabilitation program in which milieu therapy is emphasized; where clients participate in daily household management and operations, in the development of their treatment and goal plans and have significant input into the development of the program activities and exposure to the community.

How is your program designed to meet the mental health needs of any county's minority population? Not exclusively, but specifically, where possible, based on integrated staff with bilingual skills and bicultural sensitivity; it varies whenever staff turnover occurs.

MANZANITA HOUSE - 0102

24-Hour Care

	1977-78 Past Year Actual	1978-79 Estimated Current Year	1979-80 Estimated Budget Year
Unduplicated Clients Served Per Year	DATA NOT AVAILABLE		
Program Cost	D 58,560 I Total 58,560	51,329 51,329	52,254 52,254
% of Total County M.H. Budget	.2	.2	.2
Units of Service	3,864	3,285	3,285

DATA FOR 1979/80

Age Group Treated: 18-64 (16-17 served with letter of permission from guardian)

Target Group(s): MD

Primary Problems Treated:

1. Psychotic symptomatology (e.g. ambivalence, paranoid ideation).
2. Depression, social isolation and withdrawal.
3. Anti-social behavior (e.g. combativeness and/or threatening behavior).
4. Suicidal acting-out or threats of suicide.
5. Lack of communication skills and/or difficulty with interpersonal relationships.
6. Inadequate problem-solving skills.

Program Objectives: To operate 24-hour licensed facility to support residents in transition into independent community living. To involve each resident, within 30 days from date of entry, in a full daytime activity (therapeutic, vocational, education) which will facilitate independence upon graduation from the facility. To form a contact with each resident within 30 days from date of entry which will provide both resident and staff with guidelines and some measure of growth within the program. To develop, within at least 75% of the program graduates, demonstrable basic living skills necessary for independent living. To link each resident before discharge to at least one public and/or private service which is used during residency and upon discharge.

Estimated Average Duration of Treatment: 6 months.

What needs of a minority and/or handicapped population does this program meet and how? This Transitional Residential Treatment Facility serves all residents

of Alameda County and attempts to maintain a balance among the residents which is reflective of the ethnic and cultural diversity of the population of the County, served by an integrated and some bilingual staff.

What unique need does this program meet?

This program, an alternative to hospitalization, meets the client's need for a residential treatment facility which offers a comprehensive rehabilitation program in which milieu therapy is emphasized, where clients participate in daily household management and operations, in the development of their treatment and goal plans and have significant input into the development of program activities and exposure to the community.

How is your program designed to meet the mental health needs of any county's minority population? Not exclusively, but client-oriented where possible, based on integrated staff with bilingual skills and bicultural sensitivity, varying with staff changes.

24-Hour Care

	1977-78 Past Year Actual	1978-79 Estimated Current Year	1979-80 Estimated Budget Year
Unduplicated Clients Served Per Year	DATA NOT AVAILABLE		
Program Cost	D 59,796 I Total 59,796	52,013 52,013	52,925 52,925
% of Total County M.H. Budget	.2	.2	.2
Units of Service	4,864	4,015	4,015

DATA FOR 1979/80

Age Group Treated:18-64 (16-17 served with letter of permission from guardian)

Target Group(s): MD

Primary Problems Treated:

1. Psychotic symptomotology (e.g. ambivalence, paranoid ideation).
2. Depression, social isolation and withdrawal.
3. Anti-social behavior (e.g. combativeness and/or threatening behavior).
4. Suicidal acting-out or threats of suicide.
5. Lack of communication skills and/or difficulty with interpersonal relationships.
6. Inadequate problem-solving skills.

Program Objectives: To operate a 24-hour licensed facility to support residents in transition into independent community living. To involve each resident, within 30 days from date of entry, in a full daytime activity (therapeutic, vocational, educational) which will facilitate independence upon graduation from the facility. To form a contact with each resident within 30 days from date of entry which will provide both resident and staff with guidelines and some measure of growth within the program. To develop, within at least 75% of the program graduates, demonstrable basic living skills necessary for independent living. To link each resident before discharge to at least one public and/or private service which is used during residency and upon discharge.

Estimated Average Duration of Treatment: 6 months.

What needs of a minority and/or handicapped population does this program meet and how? This Transitional Residential Treatment Facility serves all residents of Alameda County and attempts to maintain a balance among the residents which is reflective of the ethnic and cultural diversity of the population of the County, served by an integrated, and some bilingual, staff.

What unique need does this program meet? This program, an alternative to hospitalization, meets the client's need for a residential treatment facility which offers a comprehensive rehabilitation program in which milieu therapy is emphasized; where clients participate in daily household management and operations, in the development of their treatment and goal plans and have significant input into the development of program activities and exposure to the community.

How is your program designed to meet the mental health needs of any county's minority population? Not exclusively, but specifically, where possible, based on integrated staff with bilingual skills and bicultural sensitivity; varying with staff changes.

24-Hour Care

	1977-78 Past Year Actual	1978-79 Estimated Current Year	1979-80 Estimated Budget Year
Unduplicated Clients Served Per Year	DATA NOT AVAILABLE		
Program Cost	D I Total 55,767	51,584	54,163
% of Total County M.H. Budget	.2	.2	.2
Units of Service	5,029	4,439	4,439

DATA FOR 1979/80

Age Group Treated:*

Target Group(s):*

Primary Problems Treated:*

Program Objectives:*

Estimated Average Duration of Treatment:*

What needs of a minority and/or handicapped population does this program meet and how?*

What unique need does this program meet?*

Is your program designed to meet the mental health needs of any county's minority population?*

*Please refer to City of Berkeley, Short-Doyle Plan, 1979/80

AMBER HOUSE - 0102

24-Hour Care

	1977-78 Past Year Actual	1978-79 Estimated Current Year	1979-80 Estimated Budget Year
Unduplicated Clients Served Per Year	DATA NOT AVAILABLE		
Program Cost	D 51,691 I Total 51,691	50,777 50,777	51,649 51,649
% of Total County M.H. Budget	.2	.2	.2
Units of Service	3,448	2,920	2,920

DATA FOR 1979/80

Age Group Treated: 18-64 (16-17 served with letter or permission of guardian).

Target Group(s): MD

Primary Problems Treated:

1. Psychotic symptomatology (e.g. ambivalence, paranoid ideation).
2. Depression, social isolation and withdrawal.
3. Anti-social behavior (e.g. combativeness and/or threatening behavior).
4. Suicidal acting-out or threats of suicide.
5. Lack of communication skills and/or difficulty with interpersonal relationships.
6. Inadequate problem-solving skills.

Program Objectives: To operate a 24-hour licensed facility to support residents in transition into independent community living. To involve each resident, within 30 days from date of entry, in a full daytime activity (thereapeutic, vocational education) which will facilitate independence upon graduation from the facility. To form a contact with each resident within 30 days from date of entry which will provide both resident and staff with guidelines and some measure of growth within the program. To develop, within at least 75% of the program graduates, demonstrable basic living skills necessary for independent living. To link each resident before discharge to at least one public and/or private service which is used during residency and upon discharge.

Estimated Average Duration of Treatment: 6 months.

What needs of a minority and/or handicapped population does this program meet and how? This Transitional Residential Treatment Facility serves all residents of Alamed a County and attempts to maintain a balance among the residents which is reflective of the ethnic and cultural diversity of the population of the County, served by an integrated and some bilingual staff.

What unique need does this program meet? This program, an alternative to hospitalization, meets the client's need for a residential treatment facility which offers a comprehensive rehabilitation program in which milieu therapy is emphasized; where clients participate in daily household management and operations, in the development of their treatment and goal plans and have significant input into the development of program activities and exposure to the community.

How is your program designed to meet the mental health needs of any county's minority population? Not exclusively, but specifically, where possible, based on integrated staff with bilingual skills and bicultural sensitivity, varying with staff changes.

24-Hour Care

	1977-78 Past Year Actual	1978-79 Estimated Current Year	1979-80 Estimated Budget Year
Unduplicated Clients Served Per Year	DATA NOT AVAILABLE		
Program Cost	D I Total 44,547	41,206	43,266
% of Total County M.H. Budget	.2	.2	.2
Units of Service	3,632	3,415	3,415

DATA FOR 1979/80

Age Group Treated:*

Target Group(s):*

Primary Problems Treated:*

Program Objectives:*

Estimated Average Duration of Treatment:*

What needs of a minority and/or handicapped population does this program meet and how?*

What unique need does this program meet?*

Is your program designed to meet the mental health needs of any county's minority population?*

*Please refer to City of Berkeley, Short-Doyle Plan, 1979/80

GUIDANCE CLINIC - 0119

Outpatient Care

	1977-78 Past Year Actual	1978-79 Estimated Current Year	1979-80 Estimated Budget Year
Unduplicated Clients Served Per Year	DATA NOT	AVAILABLE	
Program Cost	D 285,500 I 240,754 Total 526,254	263,775 205,886 469,661	361,268 231,758 393,026
% of Total County M.H. Budget	2.1	1.8	2.3
Units of Service	D 5,697 I 3,833	5,102 4,577	4,372 2,692

DEMOGRAPHIC CHARACTERISTIC (1970 CENSUS) OF AREA SERVED

	Number	% of Area	% of Discharge from service site
Indian	5,688	.5	Data not available
Black	161,282	15.0	
Chinese			
Filipino	40,786	3.0	
Japanese			
Spanish	135,028	12.0	
White	720,976	67.0	
Other	9,450	2.5	

DATA FOR 1979/80

Age Group Treated: 9-17

Target Group(s): MD, DD, DA

Primary Problems Treated: Primary areas are twofold: (1) Mental Health aspects of acting-out behavior of Probation-linked juveniles and (2) consultative services to the Juvenile Court and Probation Department. Priority is given to juveniles for whom the Juvenile Court has ordered diagnostic

evaluations. Second priority is given to crisis intervention in Juvenile Hall. Other priorities are described by the Memorandum of Understanding that governs the relationship between Mental Health, the Courts and Probation.

Program Objectives: To provide treatment (crisis and longer term) to adolescents on probation and their families. To provide diagnostic, consultative, and training services to the Juvenile Court and Probation Department. These services total 804 clinical hours per month. The hours are allotted by terms of the Memorandum of Understanding.

Estimated Average Direction of Treatment: Approximately 6 weeks.

What unique need does this program meet? Provides Mental Health services to the "high risk" population of Juvenile Court wards of Alameda County and Mental Health consultation to the Juvenile Court and Probation Department.

What needs of minority and/or handicapped population does this program meet? Meets the mental health needs of minority and/or handicapped minors through minority staffing and limited facility accessibility (do not meet 504 regulations).

DEPENDENT CHILDREN'S MENTAL HEALTH CLINIC - 0119

Outpatient Care

	1977-78 Past Year Actual	1978-79 Estimated Current Year	1979-80 Estimated Budget Year
Unduplicated Clients Served Per Year			
Program Cost	D I Total	Included in Guidance Clinic statistics	
% of Total County M.H. Budget			
Units of Service			

DEMOGRAPHIC CHARACTERISTIC (1970 CENSUS) OF AREA SERVED

	Number	% of Area	% of Discharge from service site
Indian			Data not
Black	1208	38.8	available
Chinese	297	9.5	
Filipino	149	4.8	
Japanese	1461	46.9	
Spanish			
White			
Other			

DATA FOR 1979/80

Age Group Treated: 0 - 17

Target Group(s): MD; DD

Primary Problems Treated: Priority is given to children and youth who are dependents of the Juvenile Court or at risk of becoming dependents. First priority is given to those dependent children and youth for whom the Juvenile Court has ordered diagnostic evaluations and treatment. Second priority is given to crisis intervention services to Snedigar Cottage and emergency foster homes. Third priority is given to mental health screening of children entering shelter care.

DEPENDENT CHILDREN'S MENTAL HEALTH CLINIC - 0119

Program Objectives: To provide diagnostic, treatment, crisis intervention, and consultative services to the Social Services Agency in accordance with the Memorandum of Understanding between Mental Health and Social Services. To deliver 500 hours per month of clinical services to the Social Services Agency.

Estimated Average Duration of Treatment: Approximately three to six months.

What Needs of a Minority and/or Handicapped Population Does this Program Meet and How? Provides evaluation and treatment services to dependents of the Juvenile Court including all minorities and handicapped on a County-wide basis through minority staffing and limited facility accessibility (does not meet 504 Regulations).

What Unique Need Does this Program Meet? Provides mental health services to dependents of the Juvenile Court of Alameda County, and provides mental health consultation to the Social Services Agency and to their associated institutions and programs.

Is Your Program Designed to Meet the Mental Health Needs of any County's Minority Population? This program is designed to meet the mental health needs of all juveniles, including all minorities, who are dependents of the Juvenile Court, through direct services, consultation and referral.

CHILD AND FAMILY MENTAL HEALTH CENTER, NORTH REGION - 0106

Outpatient Care

	1977-78 Past Year Actual	1978-79 Estimated Current Year	1979-80 Estimated Budget Year
Unduplicated Clients Served Per Year	DATA NOT AVAILABLE		
Program Cost	D 166,065 I 85,954 Total 252,019	188,854 109,722 298,576	193,156 144,051 337,207
% of Total County M.H. Budget	1.0	1.2	1.3
Units of Service	D 2,294 I 1,174	1,814 1,052	1,841 1,344

DEMOGRAPHIC CHARACTERISTIC (1970 CENSUS) OF AREA SERVED

	Number	% of Area	% of Discharge from service site
Indian	3,656	.6	0
Black	154,598	26.9	54.7
Chinese			
Filipino	30,982	5.4	0
Japanese			
Spanish	50,380	8.8	4.1
White	329,913	57.4	9.5
Other	5,342	.9	0

DATA FOR 1979/80

Age Group Treated: 0-17

Target Group(s): MD

Primary Problems Treated: Interpersonal and intrapsychic problems of varying severity, ranging from psychoses to adjustment reactions. The first priorities for direct services are those disturbed youngsters in imminent danger of hospitilization, out-of-home placement, or other severe disruption of their lives,

as well as youngsters with a history of psychiatric hospitalization.

Program Objectives: To provide treatment services to families with children under 18 residing in North Region; to prevent onset of disturbance or development of severe disturbance among children and adolescents.

Estimated Average Duration of Treatment: 10-12 months

What needs of a minority and/or handicapped population does this program meet and how? Through a multi-ethnic staff, treatment, consultation, education and information services are provided to minority and handicapped populations. The caseload during FY 77-78 was predominantly Black (76%) and approximately 10% of the caseload were children with identified mild to moderate brain dysfunctions, physical or developmental disabilities. C,E, and I services are provided to many agencies serving minority and/or handicapped populations (e.g. Welfare, Public Health, Headstart Centers, day care centers).

What unique need does this program meet? Treatment Services - this is the only County-operated mental health clinic serving families residing in North, West& Central Oakland; Emeryville, & Piedmont who may not have access to treatment in the private sector. Prevention Services - a variety of C,E, and I services are offered to community agencies and organizations without charge.

Is your program designed to meet the mental health needs of any county's minority population? Yes. Through recruitment of bilingual Asian clinicians and bicultural Black clinicians, and through continuing staff development activities, the Center is able to provide effective treatment services for Black families and Chinese families.

EAST OAKLAND FAMILY HEALTH CENTER

Outpatient and CE & I Care

	1977-78 Past Year Actual	1978-79 Estimated Current Year	1979-80 Estimated Budget Year
Unduplicated Clients Served Per Year	DATA NOT AVAILABLE		
Program Cost	D 94,674 I 43,329 Total 138,003	102,232 43,814 146,046	187,085 46,005 153,090
% of Total County M.H. Budget	.6%	.6%	.6%
Units of Service	D 2.628	D 2,475 I 1,700	D 1258 I 1700

DEMOGRAPHIC CHARACTERISTIC (1970 CENSUS) OF AREA SERVED

	Number	% of Area	% of Discharge from service site
Indian	1,856	1.0	1.4
Black	68,312	36.8	61.3
Chinese	4,455	2.4	0.4
Filipino	2,042	1.1	0.7
Japanese	928	0.5	0.4
Spanish	24,503	13.2	4.6
White	81,120	43.7	30.6
Other	2,413	1.3	0.6

DATA FOR 1979-80

Age Group Treated: 0-17

Target Group(s): MD

Primary Problems Treated: Neurosis, life crisis, learning disabilities, Psychosis, and situational disturbances.

EAST OAKLAND FAMILY HEALTH CENTER (Cont'd.)

Program Objectives:

1. To provide crisis and brief treatment mental health services to residents of Catchment 20.

2. To provide Adult and Child CE & I services to community agencies and groups concerning Mental Health issues and direct service problems in the community.

Estimated Average Duration of Treatment: 3 to 6 months.

What needs of a Minority and/or Handicapped Population Does this Program Meet and How? Provides culturally oriented psychotherapeutic service including group, individual, family therapy. Provides remediation for children with learning problems. Provides counseling groups for teen-agers, parents, families, and adolescent parents.

What Unit Need Does this Program Meet? Provides outpatient mental health services to children in the community.

How is Your Program Designed to Meet the Mental Health Needs of any County's Minority Population?

Located in minority community
Race of staff reflects ethnic minority population of community
Outreach and transportation services offered
Culturally oriented therapeutic services provided.

ALAMEDA COMMUNITY MENTAL HEALTH CENTER - CHILDREN - 0152

Outpatient Care

	1977-78 Past Year Actual	1978-79 Estimated Current Year	1979-80 Estimated Budget Year
Unduplicated Clients Served Per Year	DATA NOT AVAILABLE		
Program Cost	D 49,588 I 12,053 Total 61,641	63,806 12,559 76,365	68,562 17,134 85,696
% of Total County M.H. Budget	.2	.3	.3
Units of Service	D 794 I 195	427 84	794 195

DEMOGRAPHIC CHARACTERISTIC (1970 CENSUS) OF AREA SERVED

	Number	% of Area	% of Discharge from service site
Indian	10	.5	0
Black	1,924	2.6	4.9
Chinese			
Filipino *	4,155	5.6	1.2
Japanese			
Spanish	7,342	9.8	3.7
White	60,310	81.5	90.2
Other			
	74,000	100.0%	100.0%

DATA FOR 1979/80

Age Group Treated: 0-17

Target Group(s): MD

*It is estimated that 23% of school population is Asian

Primary Problems Treated: Children and youth with a history of psychiatric hospitalization at either state, local, public, or private facilities. Children and youth at risk of hospitalization by virtue of severe emotional problems and maladaptive behavior making them inaccessible to the usual services provided in the community. Counseling parents and other care givers regarding their roles and responsibilities to persons under 18.

Program Objectives: Provide outpatient treatment to children and youth under 18 to prevent hospitalization due to mental disorder. Provide outpatient treatment services to families to prevent onset of severe disturbances among children and adolescents. Provide follow-up care for children released from hospital or residential treatment facilities.

Estimated Average Duration of Treatment: 6 to 9 months

What needs of a minority and/or handicapped population does this program meet and how? By having a .5 Black psychiatrist who also speaks Spanish and a Tagalog-speaking Filipino social worker, we endeavor to be culturally relevant to our minority populations.

What unique need does this program meet? This program is the only program serving the mentally disordered child and adolescent located in Catchment Area 19.

Is your program designed to meet the mental health needs of any county's minority population? Program has Black and Filipino professional staff. Education of staff in cultural/ethnic courses helps provide more sensitive services linkages with other county and contract agencies.

TRI-CITY CHILDREN AND YOUTH SERVICE - 0122

Outpatient Care

	1977-78 Past Year Actual	1978-79 Estimated Current Year	1979-80 Estimated Budget Year
Unduplicated Clients Served Per Year	Data Unavailable	Data Unavailable	Data Unavailable
Program Cost	D 124,157 I 50,866 Total 174,023	112,145 42,310 154,455	120,047 64,777 184,824
% of Total County M.H. Budget	.7	.6	.7
Units of Service	D 1,595 I 631	1,650 939	1,331 696

DEMOGRAPHIC CHARACTERISTIC (1970 CENSUS) OF AREA SERVED

	Number	% of Area	% of Discharge from service site
Indian	806	0.4	U
Black	1,626	0.7	N
Chinese	1,177	0.5	A
Filipino	2,005	0.9	V
Japanese	1,192	0.5	A
Spanish	35,372	16.0	I
White	172,715	80.2	L
Other	1,508	0.6	A
			B
			L
			E

DATA FOR 1979/80

Age Group Treated: 0-17

Target Group(s): MD

Primary Problems Treated: Those children age 17 years and under with a history of psychiatric hospitalization at either state, local public or private facilities. Those children age 17 years and under never hospitalized but "at risk" of requiring such care if they do not receive services. Children re-

ferred from any psychiatric hospital, Placement Unit, Psychiatric Emergency Services or those defined as a "crisis case" by our outpatient service shall receive an initial appointment within five working days of the referral.

Program Objectives:

1. To provide quality outpatient psychotherapy based on a careful evaluation of the child and his family, utilizing those approaches which will most provide for lasting change in the direction of emotional health.

2. When outpatient therapy is insufficient to meet the needs of the child, it is our objective to facilitate placement in an appropriate treatment facility.

3. To provide mental health consultation to schools and other agencies having an impact on children.

4. To serve as an informed source of information to the general community on the mental health of children.

5. To support and with other agencies work toward provision of facilities to take care of unmet needs, e.g., day treatment of children and adolescents with severe psychiatric disorders.

Estimated Average Duration of Treatment: 6 - 8 months.

What Needs of Minority and/or Handicapped Population Does this Program Meet and How? 1) Minimal Spanish-speaking capability. 2) Accessible to physically disabled. 3) Availability of interpreter for hearing-impaired clients.

What Unique Need Does this Program Meet? Only public mental health clinic in area serving this population with our multi-disciplinary staffing pattern. Only agency available to low income families.

Is Your Program Designed to Meet the Mental Health Needs of any County's Minority Population? Definitely need Spanish-speaking clinician(s) in view of increasing population in Union City (+162.3% from 1970 to 1978) where population of Spanish-speaking is predominantly located.

EDEN CHILDREN'S CENTER - 0112

Outpatient Care

	1977-78 Past Year Actual	1978-79 Estimated Current Year	1979-80 Estimated Budget Year
Unduplicated Clients Served Per Year	Data Unavailable	Data Unavailable	Data Unavailable
Program Cost	D 234,081 I 64,354 Total 298,435	235,499 77,349 312,848	229,436 73,331 302,767
% of Total County M.H. Budget	1.2	1.2	1.2
Units of Service	D 2,908 I 1,024	2,920 939	2,569 806

DEMOGRAPHIC CHARACTERISTIC (1970 CENSUS) OF AREA SERVED

	Number	% of Area	% of Discharge from service site
Indian	997	.41	D
Black	2,056	.84	A
Chinese	4,825	1.96	T
Filipino	Included in "Other"		A
Japanese	Included in "Asian" (Chinese)		U
Spanish	42,095	17.11	N
White	193,701	78.75	AVAILABLE
Other	2,285	.93	
	245,959	100.00	

DATA FOR 1979-80

Age Group Treated: 0-17

Target Group(s): MD

Primary Problems Treated: Highest priority patients are those children and adolescents at risk of hospitalization or recently discharged from inpatient or residential facilities without financial resources which would provide access to the private sector of outpatient treatment. Additional priorities are established for those families in crisis, and early intervention services for pre-school children.

EDEN CHILDREN'S CENTER - 0112

Program Objectives: Maintain telephone and walk-in availability to community members with children in need of services (receiving up to 500 telephone inquiries during the year). Provision of information and referral services to families in crisis in direct interview contacts (minimum of 160 visits per year). Screening of children and adolescents residing in the Eden District for hospital and residential facility placement, with projected number of screenings of approximately 8-10 patients per year. To provide approximately 2500-3000 individual therapy interviews with parents and children per year. To continue current program of early intervention and diagnostic playgroups with pre-school children and concomitant therapeutic educational groups for the mothers of children involved. To continue working with parents of children and adolescents in conjoint or family therapy. Maintain collaborative contacts with agencies and schools around cases served. To maintain liaison relationships with additional monitoring functions in relation to Short-Doyle contracts with hospitals and residential facilities in coordination with other South Region children's clinics. To maintain regular consultation relationships with community groups around mental health needs of children.

What Needs of a Minority and/or Handicapped Population Does this Program Meet and How? Limited services to deaf children are provided. Minority children are seen in the clinic roughly in proportion to the Eden Area statistics.

What Unique Need Does this Program Meet? Provides mental health services to children, youth and families in the Eden District, also provides screening for admission to Napa State Hospital, Fred Finch Youth Center, and Lincoln Child Center. In addition, the program provides mental health consultation and diagnostic play groups for pre-school children. There is no other children's clinic in the area able to see children from low income families or families who have Medi-Cal, but who cannot keep regular appointments.

Is Your Program Designed to Meet the Mental Health Needs of any County's Minority Population? Eden Children's Center could better serve primary minority population in South Region Area (i.e., Spanish-speaking) with a bilingual, bicultural, Latino therapist.

VALLEY CHILDREN'S SERVICE - 0132

Outpatient Care

	1977-78 Past Year Actual	1978-79 Estimated Current Year	1979-80 Estimated Budget Year
Unduplicated Clients Served Per Year	DATA UNAVAILABLE	DATA UNAVAILABLE	DATA UNAVAILABLE
Program Cost	D 141,705 I 16,880 Total 158,585	145,078 20,839 165,917	132,158 45,282 177,440
% of Total County M.H. Budget	.6	.7	.7
Units of Service	D 1,966 I 236	2,195 300	1,698 552

DEMOGRAPHIC CHARACTERISTIC (1970 CENSUS) OF AREA SERVED

	Number	% of Area	% of Discharge from service site
Indian	187	.03	Not Available
Black	369	.05	"
Chinese	916	1.3	
Filipino	n/a	n/a	
Japanese	n/a	n/a	
Spanish	6,841	11.0	
White	61,338	87.0	
Other	421	.05	

DATA FOR 1979/80

Age Group Treated: 0-17

Target Group(s): MD

Primary Problems Treated: Highest priority patients are those children and adolescents at risk of hospitalization or recently discharged from inpatient or residential facilities without financial resources which would provide access to the private sector for treatment. Additional priorities are established for those families in crisis, and early intervention services for pre-school children.

VALLEY CHILDREN'S SERVICE - 0132

Program Objectives: 1) To provide quality outpatient psychotherapy based on a careful evaluation of the child and his family, utilizing those approaches which will most provide for lasting change in the direction of emotional health. 2) To continue mental health consultation to schools and other agencies having an impact on children. 3) To serve as an informed source of information to the general community on the mental health of children.

Estimated Average Duration of Treatment: Six months.

What Needs of a Minority and/or Handicapped Population Does this Program Meet and How? 1) Facility accessible to physically disabled. 2) Bilingual (Spanish) capability. 3) Availability of interpreter for hearing-impaired client.

What Unique Need Does this Program Meet? The provision of mental health services for children exhibiting clear symptomatology in families of low and moderate income, and provision of mental health consultation at no charge to community agencies serving children at risk of mental disorder.

Is Your Program Designed to Meet the Mental Health Needs of any County's Minority Population?

Our Spanish-speaking psychologist provides staff consultation and direct services to the Spanish-speaking patients of the local Public Health Care Center. She is also involved in co-leading a group for Spanish-speaking women who are socially isolated and in need of outreach services. This is in addition to her primary function of providing direct services to Spanish-speaking and bilingual patients on her caseload at Valley Children's Outpatient Service. Whenever possible, other staff are also involved in the treatment of the County's minority population.

EAST OAKLAND HEALTH ALLIANCE - CHILDREN - 0190

Outpatient Care and C. E. and I.

	1977-78 Past Year Actual	1978-79 Estimated Current Year	1979-80 Estimated Budget Year
Unduplicated Clients Served Per Year	DATA NOT AVAILABLE		
Program Cost	D 94,674 I 43,329 Total 183,003	102,232 43,814 146,046	107,085 46,005 153,090
% of Total County M.H. Budget	.6	.6	.6
Units of Service	D I 2,628	2,475 1,700	1,250 1,700

DATA FOR 1979/80

Age Group Treated: 0-17

Target Group(s): MD

Primary Problems Treated: Neurosis, life crisis, learning disabilities, psychosis and situation disturbances.

Program Objectives:

1. To provide crisis and brief treatment mental health services to residents of Catchment 20 (East Oakland) Children's services.
2. To provide child consultation, education and information services to community agencies and groups concerning mental health issues and direct service problems in the community.

Estimated Average Duration of Treatment: 3-6 months

What needs of a minority and/or handicapped population does this program meet and how? Provides culturally oriented (primarily black) psychotherapeutic services including group, individual, family therapy. Provides testing for learning disabilities and learning problems of children. Provides remediation for children with learning problems. Provides counseling groups for teenagers, parents, families, and adolescent parents.

What unique need does this program meet? To avoid institutional placement or hospitalization for children who are acutely psychotic and to provide outpatient mental health services to children residing in Catchment 20.

How is your program designed to meet the mental health needs of any county's minority population? Cultural sensitivity provided locally in minority community by staff reflecting ethnic minority population of community (primarily black), outreach and transportation services offered and culturally oriented therapeutic services provided.

FRED FINCH DAY TREATMENT - 0184

Partial Day Care

	1977-78 Past Year Actual	1978-79 Estimated Current Year	1979-80 Estimated Budget Year
Unduplicated Clients Served Per Year	DATA NOT AVAILABLE		
Program Cost	D 109,348 I Total 109,348	140,697 140,697	141,489 141,489
% of Total County M.H. Budget	14	.5	.5
Units of Service	2,698	3,025	3,025

DATA FOR 1979/80

Age Group Treated: 11-17

Target Group(s): MD

Primary Problems Treated: Child exhibiting severe emotional disturbances, learning disabilities, behavioral disorders, social maladjustment.

Program Objectives: To modify or alleviate emotional disturbances and behavioral problems; to improve self-image; to improve academic motor, and social skills; to improve school, family and community relationship; to prevent hospitalization.

Estimated Average Duration of Treatment: 6-9 months

What needs of a minority and/or handicapped population does this program meet and how? Staff include minority representation as do clients served. Program has some Spanish-speaking capability. No capability for wheelchair handicapped or deaf. Capability exists to serve visually impaired but not totally blind.

What unique need does this program meet? An alternative to institutional placement or hospitalization for children who are acutely psychotic.

How is your program designed to meet the mental health needs of any county's minority population? Through orientation and training of staff. Through consultation with minority mental health professionals. A cooperative working arrangement is established with Asian community and mental health service to

work with non-English speaking parents of Asian children and with Barrio in regard to adolescent clients.

24-Hour Care

	1977-78 Past Year Actual	1978-79 Estimated Current Year	1979-80 Estimated Budget Year
Unduplicated Clients Served Per Year	DATA NOT AVAILABLE		
Program Cost	D 169,407 I Total 169,407	194,386 194,386	198,017 198,017
% of Total County M.H. Budget	.7	.8	.8
Units of Service	3,059	3,547	3,547

DATA FOR 1979/80

Age Group Treated: 6-11

Target Group(s): MD

Primary Problems Treated: Children with a primary diagnosis of behavior disorders who because of the severity of their emotional disturbance cannot be managed in outpatient or day treatment facilities.

Program Objectives:

A. To help disturbed children develop their potential to become self-supporting, socially well-adjusted and healthy adults.
   1. To eliminate anti-social/delinquent behavior.
   2. To return child to living in the community.
B. To improve academic skills.
   1. To return child to full day attendance in a public school.

Estimated Average Duration of Treatment: 20 months

What needs of a minority and/or handicapped population does this program meet and how? Services are designed to be culturally and ethnically relevant. Bilingual capacity exists to Chinese and Spanish speaking. Staff represents Black, Hispanic, Asian, Native American and White. No capability for wheelchair clients. Visually impaired and hearing impaired can be accommodated. Children with speech and motor impairments can also be served.

What unique need does this program meet? It is the only residential treatment program serving latency aged children in Alameda County who are neither overtly

psychotic nor delinquent. Due to the Center being located within Alameda County, parents can become involved in the treatment plan which will maximize the benefits to the child.

How is your program designed to meet the mental health needs of any county's minority population? Children qualify by virtue of their diagnosis and are treated without regard to their race, color, religion, national origin or sex. Staff reflects some cultural minorities, and bilingual capability exists as stated above. Consultation and training is offered to staff, by International House, to assist with understanding cultural differences. A cooperative working arrangement exists with El Centro whereby a workshop is offered in their building. Physical Education programming offers a sensory motor stimulation program and exercises for clients with motor impairments. Speech therapy is available to program through Easter Seals for speech impaired. A thorough vision and hearing screening test is given on entrance to all, and special needs are identified.

EAST BAY ACTIVITY CENTER - 0182

Partial Day Care

	1977-78 Past Year Actual	1978-79 Estimated Current Year	1979-80 Estimated Budget Year
Unduplicated Clients Served Per Year	DATA	NOT AVAILABLE	
Program Cost	D 111,670 I Total	112,587	118,087
% of Total County M.H. Budget	.5	.5	.5
Units of Service	2,678	2,256	2,256

DATA FOR 1979/80

Age Group Treated: 0-17

Target Group(s): MD

Primary Problems Treated: Selection criteria will be based upon the inability of the child to function in a normal school setting because of atypical psychosocial developmental patterns which if untreated, would be likely to require 24-hour care in the future.

Program Objectives:

1. To avoid need for hospitalization.
2. Progress with child sufficient to attend public or private school, live at home and function in environment without the need for a highly structured setting.

Estimated Average Duration of Treatment: 48 months

What needs of a minority and/or handicapped population does this program meet and how? Census is over 50% minority. Bilingual capability exists in Spanish, Chinese and German. Clients are assisted to obtain SSI, outreach to individual by home visits are made where transportation is not available to individual. No capability to serve physically handicapped M.D.'s.

What unique need does this program meet? The need to forestall or eliminate the need for hospitalization of severely emotionally disturbed latency aged children through an intensive treatment program geared at having the children

enter the public school system and continue to live at home upon discharge from the program.

How is your program designed to meet the mental health needs of any county's minority population? Limited language capability. Referral source (Oakland Public Schools) well informed of service availability to minorities.

FRED FINCH RESIDENTIAL - 0184

24-Hour Care

	1977-78 Past Year Actual	1978-79 Estimated Current Year	1979-80 Estimated Budget Year
Unduplicated Clients Served Per Year	DATA	NOT AVAILABLE	
Program Cost	D 392,840 I Total 392,840	348,172 348,172	355,282 355,282
% of Total County M.H. Budget	1.6	1.4	1.4
Units of Service	5,346	4,555	4,555

DATA FOR 1979-80

Age Group Treated: 11-17

Target Group(s): MD

Primary Problems Treated: Emotional disturbances, mental illness, learning disabilities, perceptual and motor handicaps, behavioral disorders, social maladjustment.

Program Objectives: To modify or alleviate emotional disturbance and behavioral problems; to improve self-image of children and adolescents; to improve academic and primary vocational and motor skills; to improve social and family relationships; to prevent hospitalization.

Estimated Average Duration of Treatment: 15 months.

What needs of a minority and/or handicapped population does this program meet and how? Staff include minority representation as do clients served. Program has some Spanish-speaking capability. No capability for wheelchair handicapped or deaf. Capability exists to serve visually impaired but not totally blind.

What unique need does this program meet? This service is not available elsewhere in Alameda County to develop a healthier self-image, acceptable social behavior, and development of basic skills required for employment.

How is your program designed to meet the mental health needs of any county's minority population? Through orientation and training of staff. Through consultation with minority mental health professionals. A cooperative working arrangement has been established with the Asian Community Mental Health Service

work with non-English speaking parents of Asian children and with Barrio in regard to adolescent clients.

	1977-78 Past Year Actual	1978-79 Estimated Current Year	1979-80 Estimated Budget Year
Unduplicated Clients Served Per Year	N/A	N/A	N/A
Program Cost	D I Total 374,605	408,153	351,548
% of Total County M.H. Budget	1.5	1.5	1.4
Units of Service	3,452	3,451	3,072

DATA FOR 1979/80

Age Group Treated: N/A

Target Group(s): N/A

Primary Problems Treated: Need for current information on practice issues relevant to program priorities. Need for affirmative action training and recruitment.

Program Objectives: Develop skills in the County Staff for assessment and treatment of ethnically diverse, low income, seriously mentally disordered clientele. Enable staff to achieve and maintain licensure. Prepare 8 psychiatric residents, 8 psychology interns and 14 psychiatric social work students for community mental health practice.

Estimated Average Duration of Treatment: Staff, continuously; students, 1 to 4 years.

What needs of a minority and/or handicapped population does this program meet and how? Provide minority and handicapped clientele with mental health assessments and treatment interventions addressed to their special needs via training programs for staff.

What unique need does this program meet? Provide training specifically relevant to the program priorities and conditions within the County Mental Health Service system.

Is your program designed to meet the mental health needs of any county's minority population? Yes. In-service training deals with such issues as

ethnic cultural influences on mental illness and treatment expectations, managing ethnic differences between therapist and client, and special needs of minorities regarding service accessibility. Affirmative action recruitment of students. All students receive training concerning work with minority populations.

SPECIALIZED SERVICES UNIT - 0114

Consultation, Education and Information

	1977-78 Past Year Actual	1978-79 Estimated Current Year	1979-80 Estimated Budget Year
Unduplicated Clients Served Per Year	N/A	N/A	N/A
Program Cost	D 835,127 I Total 835,127	935,790 935,790	881,740 881,740
% of Total County M.H. Budget	3.3	3.6	3.4
Units of Service	DATA NOT AVAILABLE		

DATA FOR 1979/80

Age Group Treated: 18-65+

Target Group(s): MD

Primary Problems Treated: Severely mentally disabled persons needing: 1) A licensed residential treatment facility placement; 2) Case management services in the community; 3) Clarification and verification of funding possibilities; 4) Coordination of treatment planning with other agencies and programs including the state hospital and "L" facilities.

Program Objectives: Provide case management services to 200 chronically mentally disordered individuals by the end of 1979; continue to effect placements for approximately 40 individuals per month; continue monitoring of County contracts with Canyon Manor and Social Services Bureau Transitional Residential Facilities; develop liaison monitoring protocol with psychiatric skilled nursing facilities in the Bay Area in order to know the treatment program and to begin early planning regarding discharge.

Estimated Average Duration of Treatment: Case management - indefinite; placement - 1-3 weeks.

What needs of a minority and/or handicapped population does this program meet and how? Program has resource base of information regarding facilities that will meet special needs of minority and/or handicapped. Information regarding resources is gained through placement experience, meetings with licensing agencies and consultation with outpatient centers.

SPECIALIZED SERVICES UNIT - 0114

What unique need does this program meet?

This is a program designed to reduce the utilization of state hospital days by providing a wide range of community supportive services in the form of case management so that hospitalization can be avoided and/or stays shortened; a program uniquely able to facilitate placements into residential care facilities and to consult with other placing agencies such as private hospitals and outpatient clinics; the program provides a linkage to Alameda County for the individual who is hospitalized outside his/her county of residence.

Is your program designed to meet the mental health needs of any county's minority population? Yes, through staff composition with ethnic representation of Blacks, Asians, Hispanics and Whites and a bilingual capacity.

	1977-78 Past Year Actual	1978-79 Estimated Current Year	1979-80 Estimated Budget Year
Unduplicated Clients Served Per Year	N/A	N/A	N/A
Program Cost	D I Total 280,998	383,761	368,182
% of Total County M.H. Budget	1.1	1.5	1.4
Units of Service	13,203	13,203	20,850

DATA FOR 1979/80

Age Group Treated: 18-65+

Target Group(s): MD

Primary Problems Treated: Clients who are gravely disabled.

Program Objectives: Ensure mental health care and as authorized by Sections 5350 and 5368 of the Welfare and Institutions Code, this unit investigates the circumstances of patients judged by designated personnel to be gravely disabled and recommended for conservatorship pursuant to Section 5352. When appointed by the Court, the unit performs those duties of the temporary and permanent conservator prescribed by the code sections cited.

Estimated Average Duration of Treatment: Conservatorship renewed annually and possibly reviewed by the Court.

What unique need does this program meet? To provide the means for ensuring appropriate placement and/or treatment for persons who are gravely disabled including long-term involuntary care and treatment. To provide the means of establishing more stable and appropriate community placement.

Consultation, Education and Information

	1977-78 Past Year Actual	1978-79 Estimated Current Year	1979-80 Estimated Budget Year
Unduplicated Clients Served Per Year	N/A	N/A	N/A
Program Cost	D I Total 35,216	35,217	36,978
% of Total County M.H. Budget	.1	.1	.1
Units of Service	4,404	8,628	8,628

DATA FOR 1979/80

Age Group Treated: 0-65+

Target Group(s): MD

Primary Problems Treated: 1) 24-hour services available to potential child abusive parents and families in crisis, 2) enhance information services regarding availability of mental health and other services, 3) provide education resource for parents regarding mental health crisis, parenting skills and for community groups and schools regarding mental health needs for potentially child abusive parents.

Program Objectives: Provide 24-hour, 7 days/week crisis line for parents/caretakers. Recruit, select, train a minimum of 45 volunteers to provide consultation, education and information to parents/caretakers. Make 60 presentations to community groups and schools. Facilitate 6 parent groups with 6-8 parents regarding mental health issues and parenting skills.

Estimated Average Duration of Treatment: Groups average 8 meetings; hotline contact may range from 1 time, intake and referral care to ongoing contacts.

What needs of a minority and/or handicapped population does this program meet and how? Needs of minority and handicapped regarding parenting information and skills and information regarding services available. All group facilities are accessible to the physically disabled. All persons, except the deaf, with access to the telephone can use PSS services.

What unique need does this program meet? Prevention of child abuse and neglect;

lessening of family crisis; lessening of family disintegration.

How is your program designed to meet the mental health needs of any county's minority population? Limited bilingual volunteer capability (Spanish) available for hotline and home visits.

MENTAL HEALTH BILLING PROJECT (MH/AD)*

	1977-78 Past Year Actual	1978-79 Estimated Current Year	1979-80 Estimated Budget Year
Unduplicated Clients Served Per Year	N/A	N/A	N/A
Program Cost	D N/A I Total	N/A**	187,716
% of Total County M.H. Budget	N/A	N/A	.7
Units of Service	N/A	N/A	1,040

The Mental Health/Alcohol and Drug Abuse (MH/AD) Project, a computerized billing and accounts receivable system to be implemented July 1, 1979, will perform the following functions:

Maintain general demographic patient data and produce reports to be used for planning and evaluation.

Maintain service and staff data and produce reports to be used by providers for planning, staffing and monitoring.

Maintain data on mental health community services provided.

Produce family/patient and third-party bills.

Maintain data on each family's/patient's account and financial status, including UMDAP liability.

*Number requested
**Included with general administration for 1978-79. Amount not applicable.

SECTION IV

RESOURCES UTILIZATION

ALAMEDA COUNTY MENTAL HEALTH SERVICES, AT THIS TIME, DOES NOT HAVE THE CAPABILITY OF DETERMINING AN ACCURATE UNDUPLICATED COUNT OF PERSONS SERVED. WITH THE RECENT IMPLEMENTATION OF THE NEW BILLING SYSTEM, THIS INFORMATION WILL BE MADE AVAILABLE AS SOON AS POSSIBLE.

FORM B

AT THIS TIME, ALAMEDA COUNTY MENTAL HEALTH SERVICES IS UNABLE TO PROVIDE THE INFORMATION FOR THE INDIRECT SERVICE COSTS IN THIS FORMAT. IMPLEMENTATION OF THE NEW BILLING SYSTEM WILL IMPROVE THIS CAPABILITY AND THE INFORMATION WILL BE FORWARDED AS SOON AS POSSIBLE.

FISCAL YEAR 1979-80

FORM C

SUMMARY OF ANNUAL COSTS FOR

CONSERVATORSHIP/TRAINING

SERVICE	NUMBER OF CASES	NUMBER OF CASES	ANNUAL COST
CONSERVATORSHIP	Investigation 843	Administration	368,182

Total Adjusted Gross Cost 368,182

SERVICE	NUMBER OF HOURS	ANNUAL COST
Training	3,072	351,548

Total Adjusted Gross Cost 351,548

BUDGET SUMMARY
SHORT DOYLE PLAN FY 79-80

I. County-Wide Services (Total: $17,498,810)

Direct (Subtotal: $16,266,695)

HPIS	$3,012,333	C.J.	$ 375,034
C.J. Inpt.	1,209,814	PGC (1)	361,268
Laurel House	230,270	F.F.Y.C.	355,282
State Hospital	5,593,820	L.C.C.	198,017
L-Facility	1,269,306	E.B.A.C.	118,087
Canyon Manor - 24-hr.	45,468	Continuing Care	11,911
Canyon Manor - Partial Day	421,575	CCSS	881,740
HPES	1,451,576	AB 1229	112,012
FPES	619,182		

Indirect (Subtotal: $1,232,115)

Placement	$506,252
PGC	231,758
Parental Stress	36,978
Suicide Prev.	78,723
SSB Adm.	62,957
Creative Liv.Ctr.	127,731
MH/AD	187,716

II. North Region Services (Total: $5,128,551)

Direct (Subtotal: $4,123,688)

REGIONAL	NONE	
BERKELEY/ ALBANY	Berkeley Crisis	$130,577
	Berkeley Day Tx	128,861
	Berkeley Rehab	155,131
	Berkeley Place	43,266
	Bonita House	54,163
		$511,998
NORTH/WEST OAKLAND	N/W Oakland Adult	$344,033
	N/W Oakland Day Tx	175,799
		$519,832

Indirect (Subtotal: $1,004,883)

Asian Program	$151,289
NONE	
NONE	

(1) Includes Children's Dependency Unit at Snedigar Cottage.

II. Continued

	Direct		Indirect	
CENTRAL OAKLAND	No. Reg. Family $ Child	$ 193,156	No. Reg. Family & Child	$144,051
	Amber House	51,649	C/O Adult	132,779
	C/O Adult	556,335	C/O Day Tx	12,039
	C/O Day Tx	240,149		$288,869
	Counseling Clinics	73,094		
		$1,114,383		
EAST OAKLAND	E/O Adult/Child	$1,087,497	E/O Adult/Child	$261,894
	Gladman Day Tx	189,389	EOHA - Adult	54,122
	FFYC Day Tx	141,489	EOHA - Child	46,005
	EOHA - Adult	125,957	El Centro	54,064
	EOHA - Child	107,085		
	Laurel House	84,008	El Centro	107,235
		$1,735,425		$523,320
ALAMEDA	Alameda - Adult	$ 173,468	Alameda - Adult	$ 24,271
	Alameda - Child	68,562	Alameda - Child	17,134
		$ 242,030		$ 41,405

III. South Region Services (Total: $2,668,457)

	Direct (Subtotal: $2,140,892)		Indirect (Subtotal: $527,565)	
REGIONAL	S.R. Day Tx.	$ 295,320	S.R.Day Tx	$ 20,723
	Pre-Voc.	285,271	La Familia	107,800
		$ 580,591		$128,523
SOUTHWEST	Alizo House	$ 52,925	Eden Adult	$135,446
	Eden Adult	352,739	Eden Child	73,331
	Eden Child	229,436		$208,797
		$ 635,100		

III. Continued

	Direct		Indirect	
SOUTHWEST (Tri-City)	Manzanita House	$ 52,254	Tri-City Adult	$ 34,023
	Tri-City Adult	347,040	Tri-City Child	64,777
	Tri-City Child	120,047		$ 98,800
		$ 519,341		
VALLEY	Valley Adult	$ 273,702	Valley Adult	$ 46,163
	Valley Child	132,158	Valley Child	45,282
		$ 405,860		$ 91,445

IV. Other Services (Total: $763,782)

Administrative Support NOT "Spread" to County Providers	$ 44,052
Conservatorship	368,182
Training	351,548

V. Recapitulation

	Totals	Direct	Indirect
Countywide Services	$ 17,498,810	$ 16,266,695	$ 1,232,115
North County Services	5,128,551	4,123,668	1,004,883
South County Services	2,668,457	2,140,892	527,565
Other Services	763,782	--	--
Subtotal Direct/Indirect Services	--	22,531,255	2,764,563
GRAND TOTAL ADJUSTED GROSS MENTAL HEALTH PROGRAM	$ 26,059,600		

PROGRAM BUDGET SUMMARY

79 FISCAL YEAR

01 COUNTY OF Alameda

01 SUBMISSION TYPE
01 ORIGINAL SUBMISSION
02 FINAL SUBMISSION (SEPT)
03 BUDGET REVISION

SUBMISSION DATE: March 15, 1979

EXISTING	01 REGULAR			03 SOCIAL REHAB. SERVICES		05 DRUG ABUSE	TOTAL
	LOCAL ONLY	STATE HOSPITAL	TOTAL REGULAR	COUNTY CCS	STATE CCS		
GROSS PROGRAM	20,138,212	5,593,820	25,732,032		881,740		26,613,772
LESS: SAVINGS	554,172	-0-	554,172		-0-		554,172
ADJUSTED GROSS PROGRAM	19,584,040	5,593,820	25,177,860		881,740		26,059,600
LESS: GRANTS	1,032,113*		1,032,113				1,032,113
PATIENT FEES	173,461		173,461				173,461
PATIENT INSURANCE	160,039		160,039				160,039
MEDI-CAL FED	4,753,811		4,753,811				4,753,811
MEDI-CAL NON-FED							
MEDICARE	524,510		524,510				524,510
CONS. ADMIN.							
OTHER	1,084,766**	291,484	1,376,250				1,376,250
DH MDO/FED	112,012		112,012		372,863		484,875
TOTAL REVENUES	7,840,712	291,484	8,132,196		372,863		8,505,059
NEW EXISTING PROGRAM	11,743,328	5,302,336	17,045,664		508,877		17,554,541
NEW & EXPANDED PROGRAMS							
GROSS PROGRAM							
LESS: SAVINGS							
ADJUSTED GROSS PROGRAM	*Grants:		**Other Revenues:				
LESS: GRANTS							
PATIENT FEES	ACTEB $ 147,787		Misc. Contract revenue		$ 183,192		
PATIENT INSURANCE	NIMH 818,542		P.S.T. 6331 Credit		44,052		
MEDI-CAL FED	OCJP 65,784		Title XX - Dependency Unit		164,291		
MEDI-CAL NON-FED	$1,032,113		Sheltered Workshop Program		53,993		
MEDICARE			Excess Co. Participation		639,238		
CONS. ADMIN.					$1,084,766		
OTHER							
DH MDO/FED							
TOTAL REVENUES							
NET NEW & EXPANDED PROGRAMS							

STATE HOSPITAL LPS INPATIENT DAYS ARE: 69,817

ATTACH SHEET EXPLAINING DIFFERENCES BETWEEN THIS BUDGET SUMMARY AND THE ALLOCATIONS.

MAS 1559-B (8/78)

PROGRAM BUDGET

SUBMISSION DATE: March 15, 1979

79 FISCAL YEAR
01 COUNTY OF Alameda
1 ADMINISTRATION PROGRAM

01 PROGRAM TYPE
01 REGULAR
03 SOCIAL REHAB. SERVICES
05 DRUG ABUSE

01 SUBMISSION TYPE
01 ORIGINAL SUBMISSION (MAR)
02 FINAL SUBMISSION (SEPT)
03 BUDGET REVISION

01 BUDGET TYPE
01 EXISTING
02 NEW OR EXPANDED
03 COMPOSITE

SERVICE CODE:	20	25	30	35	35	40	40	40	40	99	
SERVICE	ADMINIS-TRATIVE SUPPORT	RESEARCH AND EVALUATION	CONSERVATORSHIP ADMINIS-TRATION	CONSERVATORSHIP INVESTIGATION		TRAINING				TOTAL	
PROVIDER NAME											
PROVIDER NUMBER / ITEMS	0100	0100	0187	0187		0100				9999	ITEMS
1 SALARIES & EMP. BENEFIT 1	1,929,435	61,201	117,416	184,040		260,988				2,553,080	1
5 OPERATING EXPENSES	619,850	72,527	13,047	20,449		69,337				795,210	5
10 EQUIPMENT	1,150	489				5,326				6,965	10
15 REMODELING											15
18 COUNTY OVERHEAD	395,252									395,252	18
28 FEE FOR SERVICE											28
40 CONTRACTS 2											40
45 GROSS COST	2,945,687	134,217	130,463	204,489		335,651				3,750,507	45
50 SAVINGS	113,121	3,693	-0-	-0-		15,743				132,557	50
51 SUBTOTAL GROSS COST	2,832,566	130,524	130,463	204,489		319,908				3,617,950	51
52 REVENUE											52
53 a. GRANTS	-0-	-0-								-0-	53
54 b. OTHER	44,052									44,052	54
57 TOTAL REVENUES 3	44,052	-0-								44,052	57
58 COST TO BE DISTRIBUTED	2,788,514	130,524								2,919,038	58
59 COST DISTRIBUTED	2,788,514	130,524								2,919,038	59
62 DIST. OF ADMIN. SUPPORT & RESEARCH & EVALUATION			12,943	20,287		31,640				64,870	62
65 ADJUSTED GROSS COST	-0-	-0-	143,406	224,776		351,548				719,730	65
68 REVENUES											68
69 a. GRANTS											69
70 b. CONS. ADMIN. 4											70
75 g. OTHER						16,748				16,748	75
76 h. DH - M.D.O./FED. FUNDS											76
77 TOTAL REVENUES			-0-	-0-		16,748				16,748	77
80 NET COST	-0-	-0-	143,406	224,776		334,800				702,982	80
82 STAFF HOUR OR CASELOAD			8,122	12,728		3,072					82
85 COST PER UNIT OF SERVICE 5 DIVIDE LINE 65 BY 82			$ 17.66	$ 17.66	$	$ 114.44	$	$	$		85

MAS 1552-A (7/78)

PROGRAM BUDGET

SUBMISSION DATE: March 15, 1979

79 FISCAL YEAR
01 COUNTY OF Alameda
2 COMMUNITY SERVICE PROGRAM

01 PROGRAM TYPE
01 REGULAR
03 SOCIAL REHAB. SERV.
05 DRUG ABUSE

45 MODE OF SERVICE
COMMUNITY SERVICE

01 SUBMISSION TYPE
01 ORIGINAL SUBMISSION (MAR)
02 FINAL SUBMISSION
03 BUDGET REVISION

01 BUDGET TYPE
01 EXISTING
02 NEW OR EXPANDED
03 COMPOSITE

ITEMS / PROVIDER NAME	No. Region Child & Fam.	Cen. Oak. Adult - OP	Cen. Oak. Day Tx	East Oak. Adult - OP	Alameda Adult - OP	Alameda Children's	Placement Unit	S.W. Eden Adult - OP	S.W. Tri-City Adult - OP	TOTAL	ITEMS
PROVIDER NUMBER	0106	0120	0120	0108	0152	0152	0114	0109	0122	9999	
COST CENTER	00	00	00	00	00	00	00	00	00		
1 SALARIES & EMP. BENEFITS 1	102,637	70,255	5,338	131,800	11,044	11,847	287,774	73,377	16,299		1
5 OPERATING EXPENSE	25,783	40,281	3,566	78,105	9,672	3,272	117,765	28,079	8,752		5
10 EQUIPMENT											10
15 REMODELING											15
28 FEE FOR SERVICE											28
40 CONTRACTS											40
45 GROSS COST 2	128,420	110,536	8,904	209,905	20,716	15,119	405,539	101,456	25,051		45
50 SAVINGS	6,354	9,145	331	8,104	674	736	22,603	4,760	1,040		50
51 SUBTOTAL GROSS COST	122,066	101,391	8,573	201,801	20,042	14,383	382,936	96,696	24,011		51
62 DIST. OF ADMIN. SUPPORT & RESEARCH & EVALUATION	21,985	31,388	3,466	60,093	4,229	2,751	123,316	38,770	10,012		62
65 ADJUSTED GROSS COST	144,051	132,779	12,039	261,894	24,271	17,134	506,252	135,466	34,023		65
68 REVENUES											68
69 a. GRANTS				107,805							69
75 g. OTHER 3	6,840	6,328	575	12,465	1,151	831	24,099	6,456	1,598		75
76 h. DH - FEDERAL FUNDS											76
77 TOTAL REVENUES	6,840	6,328	575	120,270	1,151	831	24,099	6,456	1,598		77
80 NET COST	137,211	126,451	11,464	141,624	23,120	16,303	482,153	129,010	32,425		80
82 STAFF HOURS	1,344	1,946	385	3,145	379	195	14,177	1,814	570		82
85 COST PER UNIT OF SERVICE DIVIDE LINE 65 BY 82	107.18	68.23	31.27	83.27	64.04	87.87	35.71	74.68	59.69		85

UNITS OF SERVICE RENDERED PER YEAR AND ADJUSTED GROSS COST

AGE CATEGORIES	STAFF HOURS	ADJUSTED GROSS COST
91 0 - 17		
92 18 - 64		
93 65+		
86 TOTAL		

MAS 1552-B (10-78)

PROGRAM BUDGET

SUBMISSION DATE: March 15, 1979

79 FISCAL YEAR
01 COUNTY OF Alameda
2 COMMUNITY SERVICE PROGRAM

01 PROGRAM TYPE
01 REGULAR
03 SOCIAL REHAB. SERV.
05 DRUG ABUSE

45 MODE OF SERVICE
COMMUNITY SERVICE

01 SUBMISSION TYPE
01 ORIGINAL SUBMISSION (MAR)
02 FINAL SUBMISSION
03 BUDGET REVISION

01 BUDGET TYPE
01 EXISTING
02 NEW OR EXPANDED
03 COMPOSITE

ITEMS / COST CENTER	So. Region	S.W. Eden	S.W. Tri-City	S.W.	Valley	Valley	M.H.	Asian Comm.	Parental	TOTAL	ITEMS
PROVIDER NAME	Day Tx	Children's	Children's	P.G.C.	Adult - OP	Children's	Billing Proj.	M.H.S.	Stress		
PROVIDER NUMBER	0112	0112	0122	0119	0132	0132	# Req'd.	0163	0192	9999	
COST CENTER	00	00	00	00	00	00	00	00	00		
1 SALARIES & EMP. BENEFITS 1	8,604	47,523	32,664	135,857	26,755	30,381	40,779				1
5 OPERATING EXPENSE	5,856	12,500	19,691	52,046	8,009	6,469	117,897				5
10 EQUIPMENT											10
15 REMODELING											15
28 FEE FOR SERVICE											28
40 CONTRACTS							31,500	151,289	36,978		40
45 GROSS COST 2	14,460	60,023	52,355	187,903	34,764	36,850	190,176	151,289	36,978		45
50 SAVINGS	557	3,088	2,107	8,805	1,725	1,969	2,460	-0-	-0-		50
51 SUBTOTAL GROSS COST	13,903	56,935	50,248	179,098	33,039	34,881	187,716	151,289	36,978		51
62 DIST. OF ADMIN. SUPPORT & RESEARCH & EVALUATION	6,820	16,396	14,529	52,660	13,124	10,401	-0-				62
65 ADJUSTED GROSS COST	20,723	73,331	64,777	231,758	46,163	45,282	187,716	151,289	36,978		65
68 REVENUES											68
69 a. GRANTS											69
75 g. OTHER 3	959	3,516		11,059	2,173	2,173		9,294			75
76 h. DH - FEDERAL FUNDS											76
77 TOTAL REVENUES	959	3,516	-0-	11,059	2,173	2,173	-0-	9,294	-0-		77
80 NET COST	19,764	69,815	64,777	220,699	43,990	43,109	187,716	141,995	36,978		80
82 STAFF HOURS	592	806	696	2,692	619	552	1,040	13,033	8,628		82
85 COST PER UNIT OF SERVICE DIVIDE LINE 65 BY 82	35.01	90.98	93.07	86.09	74.58	82.03	180.49	11.61	4.29		85

UNITS OF SERVICE RENDERED PER YEAR AND ADJUSTED GROSS COST

AGE CATEGORIES	STAFF HOURS	ADJUSTED GROSS COST
91 0 - 17		
92 18 - 64		
93 65+		
86 TOTAL		

MAS 1552-B (10-78)

PROGRAM BUDGET

SUBMISSION DATE: March 15, 1979

79 FISCAL YEAR
01 COUNTY OF Alameda
2 COMMUNITY SERVICE PROGRAM

01 PROGRAM TYPE
01 REGULAR
03 SOCIAL REHAB. SERV.
05 DRUG ABUSE

45 MODE OF SERVICE
COMMUNITY SERVICE

01 SUBMISSION TYPE
01 ORIGINAL SUBMISSION (MAR)
02 FINAL SUBMISSION
03 BUDGET REVISION

01 BUDGET TYPE
01 EXISTING
02 NEW OR EXPANDED
03 COMPOSITE

ITEMS / PROVIDER NAME	Suicide Prevention	SSB/EB Admin.	El Centro Short-Doyle	El Centro N.I.M.H.	E.O.H.A. Adult-NIMH	E.O.H.A. Child-NIMH	La Familia Co. Servs.	SSB/EB Creat. Liv.		TOTAL	ITEMS
PROVIDER NUMBER	0185	0102	0191	0191	0190	0190	0105	0102		9999	
COST CENTER	00	00	00	00	00	00	00	00	00		
1 SALARIES & EMP. BENEFITS 1										1,032,934	1
5 OPERATING EXPENSE										537,743	5
10 EQUIPMENT											10
15 REMODELING											15
28 FEE FOR SERVICE											28
40 CONTRACTS	78,723	62,957	107,235	54,064	54,122	46,005	107,800	127,731		858,404	40
45 GROSS COST 2	78,723	62,957	107,235	54,064	54,122	46,005	107,800	127,731		2,429,081	45
50 SAVINGS	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-		74,458	50
51 SUBTOTAL GROSS COST	78,723	62,957	107,235	54,064	54,122	46,005	107,800	127,731		2,354,623	51
62 DIST. OF ADMIN. SUPPORT & RESEARCH & EVALUATION	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-		409,940	62
65 ADJUSTED GROSS COST	78,723	62,957	107,235	54,064	54,122	46,005	107,800	127,731		2,764,563	65
68 REVENUES											68
69 a. GRANTS				33,318						141,123	69
75 d. OTHER 3		7,473						79,200		176,190	75
76 h. DH - FEDERAL FUNDS											76
77 TOTAL REVENUES	-0-	7,473	-0-	33,318	-0-	-0-	-0-	79,200		317,313	77
80 NET COST	78,723	55,484	107,235	20,746	54,122	46,005	107,800	48,531		2,447,250	80
82 STAFF HOURS	8,520	3,488	7,703	5,334	1,650	1,700	1,900	3,488		86,396	82
85 COST PER UNIT OF SERVICE DIVIDE LINE 65 BY 82	9.24	18.05	13.92	10.14	32.80	27.06	56.74	36.62		31.99	85

UNITS OF SERVICE RENDERED PER YEAR AND ADJUSTED GROSS COST

AGE CATEGORIES	STAFF HOURS	ADJUSTED GROSS COST
91 0 - 17		
92 18 - 64	DATA UNAVAILABLE	
93 65+		
86 TOTAL	86,396	2,764,563

MAS 1552-B (10-78)

PROGRAM BUDGET

SUBMISSION DATE: March 15, 1979

79 FISCAL YEAR
01 COUNTY OF Alameda
3 TREATMENT PROGRAM

01 PROGRAM TYPE
01 REGULAR
03 SOCIAL REHAB. SERV.
05 DRUG ABUSE

05 MODE OF SERVICE
05 24-HOUR CARE
10 PARTIAL-DAY CARE
15 OUTPATIENT CARE
16 RESIDENTIAL (DRUG ABUSE ONLY)
17 CENTRAL INTAKE SERV. (DRUG ABUSE ONLY)

01 SUBMISSION TYPE
01 ORIGINAL SUBMISSION (MAR)
02 FINAL SUBMISSION (SEPT)
03 BUDGET REVISION

01 BUDGET TYPE
01 EXISTING
02 NEW OR EXPANDED
03 COMPOSITE

ITEMS / PROVIDER NAME	HGH Psych. Inpatient	C.J. Psych. Inpatient	City of Berk. Berk. Place	Bonita Hse.	SSB/EB Laurel Hse.	SSB/EB Amber Hse.	SSB/EB Alizo Hse.	SSB/EB Manzanita	SSB/EB Cont. Care	TOTAL	
PROVIDER NUMBER	0101	0101	0110	0110	0102	0102	0102	0102	0102	9999	
COST CENTER	00	00	00	00	00	00	00	00	00		
1 SALARIES & EMP. BENEFIT 1	1,390,890	757,116									1
5 OPERATING EXPENSES	1,079,367	247,997									5
10 EQUIPMENT	3,000										10
15 REMODELING											15
28 FEE FOR SERVICE											28
40 CONTRACTS			43,266	54,163	84,008	51,649	52,925	52,254	11,911		40
45 GROSS COST 2	2,473,257	1,005,113	43,266	54,163	84,008	51,649	52,925	52,254	11,911		45
50 SAVINGS	73,149	40,210	-0-	-0-	-0-	-0-	-0-	-0-	-0-		50
51 SUBTOTAL GROSS COST	2,400,108	964,903	43,266	54,163	84,008	51,649	52,925	52,254	11,911		51
62 DIST. OF ADMIN. SUPPORT & RESEARCH & EVALUATION	612,225	244,911	-0-	-0-	-0-	-0-	-0-	-0-	-0-		62
65 ADJUSTED GROSS COST	3,012,333	1,209,814	43,266	54,163	84,008	51,649	52,925	52,254	11,911		65
68 REVENUES											68
69 a. GRANTS	181,495										69
70 b. PATIENT FEES 3	17,618										70
71 c. PATIENT INSURANCE	54,870										71
72 d. MEDI-CAL - FEDERAL	1,259,819										72
73 e. MEDI-CAL - NON-FED.											73
74 f. MEDICARE	249,790										74
75 g. OTHER	143,509	57,595				9,536	9,295	8,976			75
76 h. DH-M.D.O./FED. FUNDS 4											76
77 TOTAL REVENUES	1,907,101	57,595	-0-	-0-	-0-	9,536	9,295	8,976	-0-		77
80 NET COST	1,105,232	1,152,219	43,266	54,163	84,008	42,113	43,630	43,278	11,911		80
82 PATIENT DAYS OR VISITS	12,908	4,870	3,415	4,439	5,256	2,920	4,015	3,285	1,078		82
85 COST PER UNIT OF SERVICE DIVIDE LINE 65 BY 82	$ 233.36	$ 248.42	$ 12.67	$ 12.20	$ 15.98	$ 17.69	$ 13.18	$ 15.91	$ 11.05	$	85

UNITS OF SERVICE RENDERED PER YEAR AND ADJUSTED GROSS COST

AGE CATEGORIES	DEV. DISABLED	DRUG ABUSE	ALCOHOLISM	M.D.O.	MENTALLY DISORDERED	TOTAL	
91 0 - 17							91
92 18 - 64							92
93 65+							93
86 PATIENT DAYS OR VISITS							86
87 ADJUSTED GROSS COST							87

MAS 1550 C (10-78)

PROGRAM BUDGET

SUBMISSION DATE: March 15, 1979

79 FISCAL YEAR
01 COUNTY OF Alameda
3 TREATMENT PROGRAM

01 PROGRAM TYPE
01 REGULAR
03 SOCIAL REHAB. SERV.
05 DRUG ABUSE

05 MODE OF SERVICE
05 24-HOUR CARE
10 PARTIAL-DAY CARE
15 OUTPATIENT CARE
16 RESIDENTIAL (DRUG ABUSE ONLY)
17 CENTRAL INTAKE SERV. (DRUG ABUSE ONLY)

01 SUBMISSION TYPE
01 ORIGINAL SUBMISSION (MAR)
02 FINAL SUBMISSION (SEPT)
03 BUDGET REVISION

01 BUDGET TYPE
01 EXISTING
02 NEW OR EXPANDED
03 COMPOSITE

ITEMS / PROVIDER NAME	Fred Finch Youth Ctr.	Lincoln Child Ctr.	L-Facility Development	Canyon Manor SART	St. Hosp.	Gladman Inpatient				TOTAL	
PROVIDER NUMBER	0184	0183	0113	0107	0004	0180				9999	
COST CENTER	00	00	00	00	00	00	00	00	00		
1 SALARIES & EMP. BENEFIT 1										2,148,006	1
5 OPERATING EXPENSES										1,327,364	5
10 EQUIPMENT										3,000	10
15 REMODELING											15
28 FEE FOR SERVICE											28
40 CONTRACTS	355,282	198,017	1,269,306	45,468	5,593,820	-0-				7,812,069	40
45 GROSS COST 2	355,282	198,017	1,269,306	45,468	5,593,820	-0-				11,290,439	45
50 SAVINGS	-0-	-0-	-0-	-0-	-0-	-0-				113,359	50
51 SUBTOTAL GROSS COST	355,282	198,017	1,269,306	45,468	5,593,820	-0-				11,177,080	51
62 DIST. OF ADMIN. SUPPORT & RESEARCH & EVALUATION	-0-	-0-	-0-	-0-	-0-	-0-				857,136	62
65 ADJUSTED GROSS COST	355,282	198,017	1,269,306	45,468	5,593,820	-0-				12,034,216	65
68 REVENUES											68
69 a. GRANTS										181,495	69
70 b. PATIENT FEES 3	19,320	2,568								39,506	70
71 c. PATIENT INSURANCE										54,870	71
72 d. MEDI-CAL - FEDERAL										1,259,819	72
73 e. MEDI-CAL - NON-FED.											73
74 f. MEDICARE										249,790	74
75 g. OTHER		23,874			291,484					544,269	75
76 h. DH-M.D.O./FED. FUNDS4											76
77 TOTAL REVENUES	19,320	26,442	-0-	-0-	291,484	-0-				2,329,749	77
80 NET COST	335,962	171,575	1,269,306	45,468	5,302,336	-0-				9,704,467	80
82 PATIENT DAYS OR VISITS	4,555	3,547	N/A	1,460	69,817					121,565	82
85 COST PER UNIT OF SERVICE DIVIDE LINE 65 BY 82	$ 78.00	$ 55.83	$ N/A	$ 31.14	$ 80.12	$	$	$	$	$ 98.99	85

UNITS OF SERVICE RENDERED PER YEAR AND ADJUSTED GROSS COST

AGE CATEGORIES	DEV. DISABLED	DRUG ABUSE	ALCOHOLISM	M.D.O.	MENTALLY DISORDERED	TOTAL	
91 0 - 17	-	103	-	-	14,157	14,260	91
92 18 - 64	-	416	128	-	101,659	102,203	92
93 65+	-	-	-	-	5,102	5,102	93
86 PATIENT DAYS OR VISITS	-	519	128	-	120,918	121,565	86
87 ADJUSTED GROSS COST	-	51,374	12,672	-	11,970,170	12,034,216	87

MAS 1552-C (10-78)

PROGRAM BUDGET

SUBMISSION DATE: March 15, 1979

79 FISCAL YEAR
01 COUNTY OF Alameda
3 TREATMENT PROGRAM

01 PROGRAM TYPE
01 REGULAR
03 SOCIAL REHAB. SERV.
05 DRUG ABUSE

10 MODE OF SERVICE
05 24-HOUR CARE
10 PARTIAL-DAY CARE
15 OUTPATIENT CARE
16 RESIDENTIAL (DRUG ABUSE ONLY)
17 CENTRAL INTAKE SERV. (DRUG ABUSE ONLY)

01 SUBMISSION TYPE
01 ORIGINAL SUBMISSION (MAR)
02 FINAL SUBMISSION (SEPT)
03 BUDGET REVISION

01 BUDGET TYPE
01 EXISTING
02 NEW OR EXPANDED
03 COMPOSITE

ITEMS / PROVIDER NAME	Cen. Oak. Day Tx	S. Region Day Tx	City of Berk. Day Tx	W.O.H.C. Day Tx	Gladman Day Tx	N.I.M.H. F.F.T.C.	E.B.A.C.	Laurel Sub-acute	Canyon Manor SART	TOTAL	
PROVIDER NUMBER	0120	0112	0197	0170	0180	0184	0182	0102	0107	9999	
COST CENTER	00	00	00	00	00	00	00	00	00		
1 SALARIES & EMP. BENEFIT 1	114,070	130,398						68,576		313,044	1
5 OPERATING EXPENSES	76,201	88,754						7,094		172,049	5
10 EQUIPMENT											10
15 REMODELING											15
28 FEE FOR SERVICE											28
40 CONTRACTS			128,861	175,799	189,389	141,489	118,087	158,852	421,575	1,334,052	40
45 GROSS COST 2	190,271	219,152	128,861	175,799	189,389	141,489	118,087	234,522	421,575	1,819,145	45
50 SAVINGS	7,075	8,448	-0-	-0-	-0-	-0-	-0-	4,252	-0-	19,775	50
51 SUBTOTAL GROSS COST	183,196	210,704	128,861	175,799	189,389	141,489	118,087	230,270	421,575	1,799,370	51
62 DIST. OF ADMIN. SUPPORT & RESEARCH & EVALUATION	56,953	84,616	-0-	-0-	-0-	-0-	-0-	-0-	-0-	141,569	62
65 ADJUSTED GROSS COST	240,149	295,320	128,861	175,799	189,389	141,489	118,087	230,270	421,575	1,940,939	65
68 REVENUES											68
69 a. GRANTS						64,703				64,703	69
70 b. PATIENT FEES 3	699	3,496	175	250	600	250	2,595			8,065	70
71 c. PATIENT INSURANCE	3,264	3,420			600					7,284	71
72 d. MEDI-CAL - FEDERAL	156,934	141,349	57,988	88,000	70,851		33,227	79,426	383,250	1,011,025	72
73 e. MEDI-CAL - NON-FED.											73
74 f. MEDICARE	31,224	6,245			600					38,069	74
75 g. OTHER	11,442	14,063				34,839				60,344	75
76 h. DH-M.D.O./FED. FUNDS4											76
77 TOTAL REVENUES	203,563	168,573	58,163	88,250	72,651	99,792	35,822	79,426	383,250	1,189,490	77
80 NET COST	36,586	126,747	70,698	87,549	116,738	41,697	82,265	150,844	38,325	751,449	80
82 PATIENT DAYS OR VISITS	3,566	3,979	2,000	2,755	3,308	3,025	2,256	5,256	16,060	42,205	82
85 COST PER UNIT OF SERVICE DIVIDE LINE 65 BY 82	$ 67.34	$ 74.22	$ 64.43	$ 63.81	$ 57.25	$ 46.77	$ 52.34	$ 43.81	$ 26.25	$ 45.99	85

UNITS OF SERVICE RENDERED PER YEAR AND ADJUSTED GROSS COST

AGE CATEGORIES	DEV. DISABLED	DRUG ABUSE	ALCOHOLISM	M.D.O.	MENTALLY DISORDERED	TOTAL	
91 0 - 17	-	-	-	-	5,536	5,536	91
92 18 - 64	-	4	-	-	36,341	36,345	92
93 65+	-	-	-	-	324	324	93
86 PATIENT DAYS OR VISITS	-	4	-	-	42,201	42,205	86
87 ADJUSTED GROSS COST	-	184	-	-	1,940,755	1,940,939	87

MAS 1552-C (10-78)

PROGRAM BUDGET

SUBMISSION DATE: March 15, 1979

79 FISCAL YEAR
01 COUNTY OF Alameda
3 TREATMENT PROGRAM

01 PROGRAM TYPE
01 REGULAR
03 SOCIAL REHAB. SERV.
05 DRUG ABUSE

15 MODE OF SERVICE
05 24-HOUR CARE
10 PARTIAL-DAY CARE
15 OUTPATIENT CARE
16 RESIDENTIAL (DRUG ABUSE ONLY)
17 CENTRAL INTAKE SERV. (DRUG ABUSE ONLY)

01 SUBMISSION TYPE
01 ORIGINAL SUBMISSION (MAR)
02 FINAL SUBMISSION (SEPT)
03 BUDGET REVISION

01 BUDGET TYPE
01 EXISTING
02 NEW OR EXPANDED
03 COMPOSITE

ITEMS / PROVIDER NAME	HGU Psych E.R.	No. Region Child & Fam.	Cent. Oak. Adult OP	East Oak. Adult OP	Alameda Adult OP	Alameda Children's	FACH Psych. ER	Criminal Justice	S.W. Eden Adult - OP	TOTAL	
PROVIDER NUMBER	0101	0106	0120	0108	0152	0152	0112	0112	0109	9999	
COST CENTER	00	00	00	00	00	00	00	00	00		
1 SALARIES & EMP. BENEFIT 1	753,619	137,617	275,829	536,559	77,238	47,509	466,559	172,784	183,634		1
5 OPERATING EXPENSES	436,229	34,570	158,150	317,967	67,643	13,123	66,613	143,197	70,271		5
10 EQUIPMENT											10
15 REMODELING											15
28 FEE FOR SERVICE											28
40 CONTRACTS											40
45 GROSS COST 2	1,189,848	172,187	433,979	854,526	144,881	60,632	533,172	315,981	253,905		45
50 SAVINGS	40,161	8,519	12,262	32,991	4,716	2,952	20,938	12,483	11,913		50
51 SUBTOTAL GROSS COST	1,149,687	163,668	421,717	821,535	140,165	57,680	512,234	303,498	241,992		51
62 DIST. OF ADMIN. SUPPORT & RESEARCH & EVALUATION	301,889	29,488	134,618	265,962	33,303	10,882	106,948	71,536	110,747		62
65 ADJUSTED GROSS COST	1,451,576	193,156	556,335	1,087,497	173,468	68,562	619,182	375,034	352,739		65
68 REVENUES											68
69 a. GRANTS				431,221							69
70 b. PATIENT FEES 3	16,640	6,013	4,195	4,055	4,754	1,678	20,834		10,487		70
71 c. PATIENT INSURANCE	18,031	1,088	10,881	5,285	3,731	3,886	15,544		8,860		71
72 d. MEDI-CAL - FEDERAL	544,013	80,823	227,971	559,235	52,915	7,611	172,518		129,026		72
73 e. MEDI-CAL - NON-FED.											73
74 f. MEDICARE	90,549	208	21,335	44,234	8,847		23,418		21,336		74
75 g. OTHER	120,944	9,205	26,528		8,246	3,260	29,469	17,838	16,812		75
76 h. DH-M.D.O./FED. FUNDS4											76
77 TOTAL REVENUES	790,177	97,337	290,910	(1,044,030)	78,493	16,435	261,783	17,838	186,521		77
80 NET COST	661,399	95,819	265,425	43,467	94,975	52,127	357,399	357,196	166,218		80
82 PATIENT DAYS OR VISITS	8,384	1,841	9,170	18,446	3,714	794	3,483	4,935	8,234		82
85 COST PER UNIT OF SERVICE DIVIDE LINE 65 BY 82	$ 173.14	$ 104.92	$ 60.67	$ 58.96	$ 46.70 (46.71)	$ 86.35	$ 177.72 (177.77)	$ 75.99	$ 42.84	$	85

UNITS OF SERVICE RENDERED PER YEAR AND ADJUSTED GROSS COST

AGE CATEGORIES	DEV. DISABLED	DRUG ABUSE	ALCOHOLISM	M.D.O.	MENTALLY DISORDERED	TOTAL	
91 0 - 17							91
92 18 - 64							92
93 65+							93
86 PATIENT DAYS OR VISITS							86
87 ADJUSTED GROSS COST							87

MAS 1552-C (10-78)

PROGRAM BUDGET

SUBMISSION DATE: March 15, 1979

79 FISCAL YEAR
01 COUNTY OF Alameda
3 TREATMENT PROGRAM

01 PROGRAM TYPE
01 REGULAR
03 SOCIAL REHAB. SERV.
05 DRUG ABUSE

15 MODE OF SERVICE
05 24-HOUR CARE
10 PARTIAL-DAY CARE
15 OUTPATIENT CARE
16 RESIDENTIAL (DRUG ABUSE ONLY)
17 CENTRAL INTAKE SERV. (DRUG ABUSE ONLY)

01 SUBMISSION TYPE
01 ORIGINAL SUBMISSION (MAR)
02 FINAL SUBMISSION (SEPT)
03 BUDGET REVISION

01 BUDGET TYPE
01 EXISTING
02 NEW OR EXPANDED
03 COMPOSITE

ITEMS / PROVIDER NAME / PROVIDER NUMBER / COST CENTER	S.W.Tri-City Adult - OP 0122 00	Pre-Voc. Training 0112 00	S.W. Eden Children's 0112 00	S.W.Tri-City Children's 0122 00	S.W. P.G.C. 0119 00	Valley Adult OP 0132 00	Valley Children's 0132 00	AB 1229 # Req'd. 00	B/A Crisis 0197 00	TOTAL 9999	
1 SALARIES & EMP. BENEFIT 1	162,618	181,386	148,207	60,449	211,337	156,374	88,572	111,162			1
5 OPERATING EXPENSES	87,322	115,609	38,981	36,440	80,962	46,808	18,858	2,787			5
10 EQUIPMENT											10
15 REMODELING											15
28 FEE FOR SERVICE											28
40 CONTRACTS									130,577		40
45 GROSS COST 2	249,940	296,995	187,188	96,889	292,299	203,182	107,430	113,949	130,577		45
50 SAVINGS	10,381	11,724	9,630	3,899	13,696	10,081	5,740	1,937	-0-		50
51 SUBTOTAL GROSS COST	239,559	285,271	177,558	92,990	278,603	193,101	101,690	112,012	130,577		51
62 DIST. OF ADMIN. SUPPORT & RESEARCH & EVALUATION	107,481	-0-	51,878	27,057	82,665	80,601	30,468	-0-	-0-		62
65 ADJUSTED GROSS COST	347,040	285,271	229,436	120,047	361,268	273,702	132,158	112,012	130,577		65
68 REVENUES											68
69 a. GRANTS		147,787									69
70 b. PATIENT FEES 3	14,542		6,852	5,453	139	14,542	7,831		1,375		70
71 c. PATIENT INSURANCE	12,435		6,062	2,953	155	4,352	622				71
72 d. MEDI-CAL - FEDERAL	84,809		46,029	37,693	21,023	71,399	31,169		13,058		72
73 e. MEDI-CAL - NON-FED.											73
74 f. MEDICARE	15,612			520	104	6,765	208				74
75 g. OTHER	16,556	67,609	10,931	5,689	181,550	13,040	6,265				75
76 h. DH-M.D.O./FED. FUNDS4								112,012			76
77 TOTAL REVENUES	143,954	215,396	69,874	52,308	202,971	110,098	46,095	112,012	14,433		77
80 NET COST	203,086	69,875	159,562	67,739	158,297	163,604	86,063	-0-	116,144		80
82 PATIENT DAYS OR VISITS	7,083	4,346	2,569	1,331	4,372	4,688	1,698	339	2,200		82
85 COST PER UNIT OF SERVICE DIVIDE LINE 65 BY 82	$ 49.00	$ 65.64	$ 89.31	$ 90.19	$ 82.63	$ 58.38	$ 77.83	$ 330.42	$ 59.35	$	85

UNITS OF SERVICE RENDERED PER YEAR AND ADJUSTED GROSS COST

AGE CATEGORIES	DEV. DISABLED	DRUG ABUSE	ALCOHOLISM	M.D.O.	MENTALLY DISORDERED	TOTAL	
91 0 - 17							91
92 18 - 64							92
93 65+							93
86 PATIENT DAYS OR VISITS							86
87 ADJUSTED GROSS COST							87

MAS 1552-C (10-78)

PROGRAM BUDGET

SUBMISSION DATE: March 15, 1979

79 FISCAL YEAR
01 COUNTY OF Alameda
3 TREATMENT PROGRAM

01 PROGRAM TYPE
01 REGULAR
03 SOCIAL REHAB. SERV.
05 DRUG ABUSE

15 MODE OF SERVICE
05 24-HOUR CARE
10 PARTIAL-DAY CARE
15 OUTPATIENT CARE
16 RESIDENTIAL (DRUG ABUSE ONLY)
17 CENTRAL INTAKE SERV. (DRUG ABUSE ONLY)

01 SUBMISSION TYPE
01 ORIGINAL SUBMISSION (MAR)
02 FINAL SUBMISSION (SEPT)
03 BUDGET REVISION

01 BUDGET TYPE
01 EXISTING
02 NEW OR EXPANDED
03 COMPOSITE

ITEMS / PROVIDER NAME	B/A Rehab.	W.O.H.C. Adult OP	E.O.H.A. Adult	Couns. Clin. OCJP	D.V.R.	E.O.H.A. Children's				TOTAL	
PROVIDER NUMBER	0197	0170	0190	0161	0165	0190				9999	
COST CENTER	00	00	00	00	00	00	00	00	00		
1 SALARIES & EMP. BENEFIT 1										3,771,453	1
5 OPERATING EXPENSES										1,735,530	5
10 EQUIPMENT											10
15 REMODELING											15
28 FEE FOR SERVICE											28
40 CONTRACTS	155,131	344,033	125,957	73,094	-0-	107,085				935,877	40
45 GROSS COST 2	155,131	344,033	125,957	73,094	-0-	107,085				6,442,860	45
50 SAVINGS	-0-	-0-	-0-	-0-	-0-	-0-				214,023	50
51 SUBTOTAL GROSS COST	155,131	344,033	125,957	73,094	-0-	107,085				6,228,837	51
62 DIST. OF ADMIN. SUPPORT & RESEARCH & EVALUATION	-0-	-0-	-0-	-0-	-0-	-0-				1,445,523	62
65 ADJUSTED GROSS COST	155,131	344,033	125,957	73,094	-0-	107,085				7,674,360	65
68 REVENUES											68
69 a. GRANTS				65,784						644,792	69
70 b. PATIENT FEES 3	750	750	2,800			2,200				125,890	70
71 c. PATIENT INSURANCE			2,240			1,760				97,885	71
72 d. MEDI-CAL - FEDERAL	85,321	154,815	88,400			75,139				2,482,967	72
73 e. MEDI-CAL - NON-FED.											73
74 f. MEDICARE		1,500	1,128			887				236,651	74
75 g. OTHER			395			310				534,647	75
76 h. DH-M.D.O./FED. FUNDS4										112,012	76
77 TOTAL REVENUES	86,071	157,065	94,963	65,784	-0-	80,296				4,234,844	77
80 NET COST	69,060	186,968	30,994	7,310	-0-	26,789				3,439,516	80
82 PATIENT DAYS OR VISITS	2,500	5,744	2,475	1,150		1,250				100,746	82
85 COST PER UNIT OF SERVICE DIVIDE LINE 65 BY 82	$ 62.05	$ 59.89	$ 50.89	$ 63.56	$	$ 85.67	$	$	$	$ 76.18	85

UNITS OF SERVICE RENDERED PER YEAR AND ADJUSTED GROSS COST

AGE CATEGORIES	DEV. DISABLED	DRUG ABUSE	ALCOHOLISM	M.D.O.	MENTALLY DISORDERED	TOTAL	
91 0 - 17	-	77	11	-	13,247	13,335	91
92 18 - 64	42	1,069	1,602	-	82,933	85,646	92
93 65+	-	8	58	-	1,699	1,765	93
86 PATIENT DAYS OR VISITS	42	1,154	1,671	-	97,879	100,746	86
87 ADJUSTED GROSS COST	3,200	87,910	127,287		7,455,963	7,674,360	87

MAS 1552-C (10-78)

PROGRAM BUDGET

SUBMISSION DATE: March 15, 1979

79 FISCAL YEAR
01 COUNTY OF Alameda
3 TREATMENT PROGRAM

03 PROGRAM TYPE
01 REGULAR
03 SOCIAL REHAB. SERV.
05 DRUG ABUSE

15 MODE OF SERVICE
05 24-HOUR CARE
10 PARTIAL-DAY CARE
15 OUTPATIENT CARE
16 RESIDENTIAL (DRUG ABUSE ONLY)
17 CENTRAL INTAKE SERV. (DRUG ABUSE ONLY)

01 SUBMISSION TYPE
01 ORIGINAL SUBMISSION (MAR)
02 FINAL SUBMISSION (SEPT)
03 BUDGET REVISION

01 BUDGET TYPE
01 EXISTING
02 NEW OR EXPANDED
03 COMPOSITE

ITEMS / COST CENTER										TOTAL	
PROVIDER NAME	CCSS										
PROVIDER NUMBER	0090										
	00	00	00	00	00	00	00	00	00	9999	
1 SALARIES & EMP. BENEFIT 1											1
5 OPERATING EXPENSES											5
10 EQUIPMENT											10
15 REMODELING											15
28 FEE FOR SERVICE											28
40 CONTRACTS	881,740									881,740	40
45 GROSS COST 2	881,740									881,740	45
50 SAVINGS	-0-									-0-	50
51 SUBTOTAL GROSS COST	881,740									881,740	51
62 DIST. OF ADMIN. SUPPORT & RESEARCH & EVALUATION	-0-									-0-	62
65 ADJUSTED GROSS COST	881,740									881,740	65
68 REVENUES											68
69 a. GRANTS											69
70 b. PATIENT FEES 3											70
71 c. PATIENT INSURANCE											71
72 d. MEDI-CAL - FEDERAL											72
73 e. MEDI-CAL - NON-FED.											73
74 f. MEDICARE											74
75 g. OTHER											75
76 h. DH-M.D.O./FED. FUNDS4	372,863									372,863	76
77 TOTAL REVENUES	372,863									372,863	77
80 NET COST	508,877									508,877	80
82 PATIENT DAYS OR VISITS											82
85 COST PER UNIT OF SERVICE DIVIDE LINE 65 BY 82	$	$	$	$	$	$	$	$	$	$	85

UNITS OF SERVICE RENDERED PER YEAR AND ADJUSTED GROSS COST

AGE CATEGORIES	DEV. DISABLED	DRUG ABUSE	ALCOHOLISM	M.D.O.	MENTALLY DISORDERED	TOTAL	
91 0 - 17							91
92 18 - 64							92
93 65+							93
86 PATIENT DAYS OR VISITS							86
87 ADJUSTED GROSS COST							87

MAS 1552-C (10-78)

REPORT OF GRANT ACTIVITY

INSTRUCTIONS: THIS FORM MUST BE COMPLETED FOR EACH COUNTY PROVIDER AS WELL AS CONTRACT SHORT-DOYLE PROVIDER. THE INFORMATION SHOULD BE COMPLETE AND REFLECT ALL GRANT REVENUE FOR MENTAL HEALTH ACTIVITY BEING RECEIVED BY THE PROVIDER, AS WELL AS APPLICATIONS PENDING. THE AMOUNTS IN COLUMN 6 OF SECTION "A" SHOULD CORRESPOND TO THE GRANT REVENUES INDICATED ON THE PROGRAM BUDGET FORMS NUMBERED MH 1552 A, B, & C IN THE COUNTY SHORT-DOYLE PLAN. A FORM FOR EACH PROVIDER MUST BE SUBMITTED WITH THE COUNTY PLAN

PROVIDER NAME: Highland General Hospital

PROVIDER NUMBER: 0101

REPORT FOR FISCAL YEAR 19 79-80

DATE COMPLETED: March 30, 1979

A. List ALL grants included on the CR/DC Budget forms designed to benefit Short Doyle services. Include accurately allocated portions of general grants such as Community Mental Health Centers Staffing Grants.

1. Grant Amounts received this Fiscal Year	2. Brief Titles	3. Granting Agencies	4. Termination Date	5. % Local Match	6. Amt. of grt. designated to benefit S-D services
59,657	National Institute of Mental	National Institute of			
	Health Staffing Grant #09-H-000209-	Mental Health	11-30-81	30%*	59,657
	06-0 & 07-0. Federal Catchment				
	Area #20, East Oakland Community	(Psychiatric Inpatient Service)			
	Mental Health Center.				
59,657	=TOTAL *Grant funds cover 70% of eligible staffing cost only. Short-Doyle funds are included as part of matching requirements			TOTAL =	59,657

B. List ALL other grant awards being received by this provider for Mental Health Programs.

1. Grant Amount received during this Fiscal Year	2. Brief Titles	3. Granting Agencies	4. Beginning Date	5. Termination Date	6. % Local Match Required
	= TOTAL				

C. List ALL grant applications pending for Mental Health Programs.

1. 12 Month Amt.	2. Brief Titles	3. Granting Agency	4. Beginning Date	5. Termination Date	6. % Local Match. Req.

TO BE COMPLETED BY COUNTY MENTAL HEALTH SERVICES:

Have each of the above applications been reviewed to determine if they meet a need in the community, do not duplicate existing services, and contain a reasonable plan for continued funding as the grant declines?

YES ☐ NO ☐

SIGNATURE: _____

TITLE: _____

State of California
Department of Health
MH 1902(12/73)

REPORT OF GRANT ACTIVITY

INSTRUCTIONS: THIS FORM MUST BE COMPLETED FOR EACH COUNTY PROVIDER AS WELL AS CONTRACT SHORT-DOYLE PROVIDER. THE INFORMATION SHOULD BE COMPLETE AND REFLECT ALL GRANT REVENUE FOR MENTAL HEALTH ACTIVITY BEING RECEIVED BY THE PROVIDER, AS WELL AS APPLICATIONS PENDING. THE AMOUNTS IN COLUMN 6 OF SECTION "A" SHOULD CORRESPOND TO THE GRANT REVENUES INDICATED ON THE PROGRAM BUDGET FORMS NUMBERED MH 1552 A, B, & C IN THE COUNTY SHORT-DOYLE PLAN. A FORM FOR EACH PROVIDER MUST BE SUBMITTED WITH THE COUNTY PLAN

PROVIDER NAME: East Oakland Community Menta Health Center

PROVIDER NUMBER: 0108

REPORT FOR FISCAL YEAR 19 79-80

DATE COMPLETED: March 30, 1979

A. List ALL grants included on the CR/DC Budget forms designed to benefit Short Doyle services. Include accurately allocated portions of general grants such as Community Mental Health Centers Staffing Grants.

1. Grant Amounts received this Fiscal Year	2. Brief Titles	3. Granting Agencies	4. Termination Date	5. % Local Match	6. Amt. of grt. designated to benefit S-D services
581,218	National Institute of Mental	National Institute of			
	Health Staffing Grant #09-H-000209-	Mental Health	11-30-81	30%*	58,218
	06-0 & 07-0. Federal Catchment				
	Area #20, East Oakland Community				
	Mental Health Center.				
581,218	*Grant funds cover 70% of eligible staffing cost only. Short-Doyle funds are included as part of matching requirements =TOTAL			TOTAL =	58,218

B. List ALL other grant awards being received by this provider for Mental Health Programs.

1. Grant Amount received during this Fiscal Year	2. Brief Titles	3. Granting Agencies	4. Beginning Date	5. Termination Date	6. Local Match Required
116,673	National Institute of Mental	National Institute of			
	Health Conversion Grant for	Mental Health	12-1-77	11-30-79	*None
	Catchment Area #20, "Specialized				
	Services to the Elderly"				
	*2 year conversion grant, no matching requirement.				
	Annual grant amount $197,937. = TOTAL				

C. List ALL grant applications pending for Mental Health Programs.

1. 12 Month Amt.	2. Brief Titles	3. Granting Agency	4. Beginning Date	5. Termination Date	6. % Local Match. Req.

TO BE COMPLETED BY COUNTY MENTAL HEALTH SERVICES:

Have each of the above applications been reviewed to determine if they meet a need in the community, do not duplicate existing services, and contain a reasonable plan for continued funding as the grant declines?

YES ☐ NO ☐

SIGNATURE: _____

TITLE: _____

State of California
Department of Health
MH 1902(12/73)

REPORT OF GRANT ACTIVITY

INSTRUCTIONS: THIS FORM MUST BE COMPLETED FOR EACH COUNTY PROVIDER AS WELL AS CONTRACT SHORT-DOYLE PROVIDER. THE INFORMATION SHOULD BE COMPLETE AND REFLECT ALL GRANT REVENUE FOR MENTAL HEALTH ACTIVITY BEING RECEIVED BY THE PROVIDER, AS WELL AS APPLICATIONS PENDING. THE AMOUNTS IN COLUMN 6 OF SECTION "A" SHOULD CORRESPOND TO THE GRANT REVENUES INDICATED ON THE PROGRAM BUDGET FORMS NUMBERED MH 1552 A, B, & C IN THE COUNTY SHORT-DOYLE PLAN. A FORM FOR EACH PROVIDER MUST BE SUBMITTED WITH THE COUNTY PLAN

PROVIDER NAME: Fred Finch Youth Center

PROVIDER NUMBER: 0184

REPORT FOR FISCAL YEAR 19 79-80

DATE COMPLETED: March 30, 1979

A. List ALL grants included on the CR/DC Budget forms designed to benefit Short Doyle services. Include accurately allocated portions of general grants such as Community Mental Health Centers Staffing Grants.

1. Grant Amounts received this Fiscal Year	2. Brief Titles	3. Granting Agencies	4. Termination Date	5. % Local Match	6. Amt. of grt. designated to benefit S-D services
62,836	National Institute of Mental	National Institute of			
	Health Staffing Grant #09-H-000209-	Mental Health	11-30-81	30%*	62,836
	06-0 & 07-0. Federal Catchment				
	Area #20, East Oakland Community				
	Mental Health Center.				
62,836	=TOTAL			TOTAL =	62,836

*Grant funds cover 70% of eligible staffing cost only. Short-Doyle funds are included as part of matching requirements

B. List ALL other grant awards being received by this provider for Mental Health Programs.

1. Grant Amount received during this Fiscal Year	2. Brief Titles	3. Granting Agencies	4. Beginning Date	5. Termination Date	6. % Local Match Required
	= TOTAL				

C. List ALL grant applications pending for Mental Health Programs.

1. 12 Month Amt.	2. Brief Titles	3. Granting Agency	4. Beginning Date	5. Termination Date	6. % Local Match. Req.

TO BE COMPLETED BY COUNTY MENTAL HEALTH SERVICES:

Have each of the above applications been reviewed to determine if they meet a need in the community, do not duplicate existing services, and contain a reasonable plan for continued funding as the grant declines?

YES ☐ NO ☐

SIGNATURE: _____

TITLE: _____

State of California
Department of Health
MH 1902(12/73)

REPORT OF GRANT ACTIVITY

INSTRUCTIONS: THIS FORM MUST BE COMPLETED FOR EACH COUNTY PROVIDER AS WELL AS CONTRACT SHORT-DOYLE PROVIDER. THE INFORMATION SHOULD BE COMPLETE AND REFLECT ALL GRANT REVENUE FOR MENTAL HEALTH ACTIVITY BEING RECEIVED BY THE PROVIDER, AS WELL AS APPLICATIONS PENDING. THE AMOUNTS IN COLUMN 6 OF SECTION "A" SHOULD CORRESPOND TO THE GRANT REVENUES INDICATED ON THE PROGRAM BUDGET FORMS NUMBERED MH 1552 A, B, & C IN THE COUNTY SHORT-DOYLE PLAN. A FORM FOR EACH PROVIDER MUST BE SUBMITTED WITH THE COUNTY PLAN

PROVIDER NAME: El Centro de Salud Mental

PROVIDER NUMBER: 0191

REPORT FOR FISCAL YEAR 19 79-80

DATE COMPLETED: March 30, 1979

A. List ALL grants included on the CR/DC Budget forms designed to benefit Short Doyle services. Include accurately allocated portions of general grants such as Community Mental Health Centers Staffing Grants.

1. Grant Amounts received this Fiscal Year	2. Brief Titles	3. Granting Agencies	4. Termination Date	5. % Local Match	6. Amt. of grt. designated to benefit S-D services
32,357	National Institute of Mental	National Institute of			
	Health Staffing Grant #09-H-000209-	Mental Health	11-30-81	30%*	32,357
	06-0 & 07-0. Federal Catchment				
	Area #20, East Oakland Community				
	Mental Health Center.				
32,357	=TOTAL *Grant funds cover 70% of eligible staffing cost only. Short-Doyle funds are included as part of matching requirements			TOTAL =	32,357

B. List ALL other grant awards being received by this provider for Mental Health Programs.

1. Grant Amount received during this Fiscal Year	2. Brief Titles	3. Granting Agencies	4. Beginning Date	5. Termination Date	6. % Local Match Required
	= TOTAL				

C. List ALL grant applications pending for Mental Health Programs.

1. 12 Month Amt.	2. Brief Titles	3. Granting Agency	4. Beginning Date	5. Termination Date	6. % Local Match. Req.

TO BE COMPLETED BY COUNTY MENTAL HEALTH SERVICES:

Have each of the above applications been reviewed to determine if they meet a need in the community, do not duplicate existing services, and contain a reasonable plan for continued funding as the grant declines?

YES ☐ NO ☐

SIGNATURE: _____

TITLE: _____

State of California
Department of Health
MH 1902 (12/73)

REPORT OF GRANT ACTIVITY

INSTRUCTIONS: THIS FORM MUST BE COMPLETED FOR EACH COUNTY PROVIDER AS WELL AS CONTRACT SHORT-DOYLE PROVIDER. THE INFORMATION SHOULD BE COMPLETE AND REFLECT ALL GRANT REVENUE FOR MENTAL HEALTH ACTIVITY BEING RECEIVED BY THE PROVIDER, AS WELL AS APPLICATIONS PENDING. THE AMOUNTS IN COLUMN 6 OF SECTION "A" SHOULD CORRESPOND TO THE GRANT REVENUES INDICATED ON THE PROGRAM BUDGET FORMS NUMBERED MH 1552 A, B, & C IN THE COUNTY SHORT-DOYLE PLAN. A FORM FOR EACH PROVIDER MUST BE SUBMITTED WITH THE COUNTY PLAN

PROVIDER NAME: ~~Counseling Clinics Inc~~

PROVIDER NUMBER: _____

REPORT FOR FISCAL YEAR 19 79-80

DATE COMPLETED: March 30, 1979

A. List ALL grants included on the CR/DC Budget forms designed to benefit Short Doyle services. Include accurately allocated portions of general grants such as Community Mental Health Centers Staffing Grants.

1. Grant Amounts received this Fiscal Year	2. Brief Titles	3. Granting Agencies	4. Termination Date	5. % Local Match	6. Amt. of grt. designated to benefit S-D services
69,439	Psychotherapeutic Program for High Risk Children & Adolescents	Office of Criminal Justice		5%	69,439
69,439	=TOTAL			TOTAL =	69,439

B. List ALL other grant awards being received by this provider for Mental Health Programs.

1. Grant Amount received during this Fiscal Year	2. Brief Titles	3. Granting Agencies	4. Beginning Date	5. Termination Date	6. % Local Match Required
	= TOTAL				

C. List ALL grant applications pending for Mental Health Programs.

1. 12 Month Amt.	2. Brief Titles	3. Granting Agency	4. Beginning Date	5. Termination Date	6. % Local Match. Req

TO BE COMPLETED BY COUNTY MENTAL HEALTH SERVICES:

Have each of the above applications been reviewed to determine if they meet a need in the community, do not duplicate existing services, and contain a reasonable plan for continued funding as the grant declines?

YES ☐ NO ☐

SIGNATURE: _____

TITLE: _____

State of California
Department of Health
MH 1902(12/73)

SECTION V

SPECIAL REPORTS

MEMORANDUM OF UNDERSTANDING
Between
Alameda County Mental Health Services
And
Program V, Napa State Hospital

This agreement is entered into by Mental Health Services Agency of Alameda County and Program V of Napa State Hospital regarding the operational guidelines by which each agency interfaces with the other. The provisions herein are based upon the continuing availability of current resources to both Alameda County Mental Health Services and Napa State Hospital Program V. Should there be a change in the availability of such resources to either party which significantly affects this agreement, either party reserves the right to renegotiate the services described herein.

Further, each party agrees to have designees review the provisions of this agreement on a quarterly basis beginning on January 1, 1978, and meet as needed to establish and maintain mutually agreeable referral and service procedures that may be of concern. Mental Health Services of Alameda County agrees to:

A. Evaluate patients as to the clinical need for Napa State Hospital (NSH) care according to the following criteria:

   1. Patients with a history of repeated failures at residential care facilities, and those in need of long-term hospitalization.

   2. Patients in need of extended evaluations (1-2 months), to determine need for conservatorship and/or transfer to Skilled Nursing Facility or other appropriate community resource.

   3. Patients in need of short-term hospitalization (up to 6 weeks), for purposes of stabilization, outpatient referral, and if necessary, placement into residential care facilities.

   4. Patients 60 years or older will be sent to NSH only after telephoning the director of Program V to verify acceptability.

   5. Patients in seven months pregnancy or more will not be sent to Program V and will not be sent to NSH unless special arrangements have been made with the Program VII director per attached NSH Policy and Procedure 564, Attachment A.

   6. Criminal Justice patients sent to NSH will be screened by Highland Psychiatric Emergency Service (HPES) and Criminal Justice Mental Health Unit (CJMHU) to exclude patients with:

      a. Bail of $10,000 or more.
      b. Potential escape risks.
      c. Serious felony charges, i.e. murder, rape.

All Criminal Justice patients not excluded by the above criteria must be approved by the director of Program V, Clinical Director or Executive Director.

B. Transfer patients to NSH when the following criteria have been met:

1. Admissions to NSH from Highland Psychiatric Inpatient Service (HPIS) will be arranged to insure arrival at NSH during their normal working hours (9:00 - 4:00).

2. Admissions from HPES are dependent upon availability of resources and will occur after normal working hours only when no other alternatives are available and NSH has been called to relate emergency nature of the case and confirm that a bed is available.

3. Necessary admission papers (Short-Doyle approval, legal paper, etc.) will accompany patients sent to NSH.

4. Patients on 14-day certification will be transferred with sufficient remaining time to allow for evaluation and possible conservatorship application by NSH.

C. Provide the following to Program V:

1. Accurate information regarding Alameda County's outpatient service, community resources and residential care facilities.

2. Staff visits to Alameda County community facilities, upon request, will be arranged.

3. Pertinent, legible information regarding Alameda County client's past treatment, recommendations and/or proceedings for conservatorships, reason for hospitalization at NSH, current medication, letter of referral for conservatorship, status of conservatorship proceedings, and disposition recommendation as available in accordance with procedure forms developed by HPES and HPIS.

4. Onsite monitoring and assessments of clients and assistance in the disposition planning for all Alameda County patients at NSH.

5. Placement services (including preplacement visits) for all Alameda County patients at NSH.

6. Forward discharge summaries from NSH records to appropriate outpatient clinics.

7. Provide direct telephone contact with designated clinical staff at each County center site to provide background information, medication, and level of recommended follow-up for Alameda County clients being discharged from Napa. Alameda County outpatient service will then provide NSH staff with specified appointment time and clinician name within one week.

Program V of NSH agrees to:

1. Provide Alameda County Mental Health Services with accurate information regarding Program V inpatient program services and procedures.

2. Arrange, on request, for Alameda County Mental Health Service staff visits to NSH.

3. Provide sufficient office space for Placement Unit in proximity to Program V wards.

4. Establish system whereby the ward social workers shall be reasonably available on behalf of each ward as the main contact for placement specialist monitoring Alameda County patients. Within the first week of patient admission, the ward social worker will begin discussion with placement specialist regarding treatment plan and progress, need for conservatorship, outpatient or residential care resource, or transfer to IPR program.

5. Through the ward social worker, write social history evaluations as prescribed by hospital policy.

6. Through the ward social worker, make referrals to outpatient service for all cases not involved in placement who indicate even the slightest motivation for follow-up at the time of discharge.

7. Whenever possible include placement specialist in discussions about referring patients to IPR programs before referral is made. Program V secretary shall make available to placement unit a weekly update of the IPR referral list.

8. Through the ward social worker, assist the placement specialist in the preparation of the client for placement. Referrals (State form #09.004) should specify identified needs of each client in relation to community resources based on adequate discussion with the client, conservator and/or placement specialist. A tentative plan should differentiate the type of placement needed, according to the criteria described in Attachment B per use of residential care facilities. A specific description of the client's history of and potential for dangerous behavior, if any, shall be included in or attached to the referral. At the time of referral, any outstanding medical or dental treatments by the hospital should be at or near completion so as to prevent delays in implementing placement. Materials to accompany placement referrals are as follows:

   a. Halfway houses - current medical report, TB report, psychiatric report and social history.
   b. Residential care facilities - current medical report, TB report and social history.

c. SNF - medical report, TB report, psychiatric report, social history and MC 170 signed by ward physician.

9. Upon request of placement unit, Patient Services Technician (PST) and through the ward social worker, consult with the PST regarding client's ability to manage his/her own SSI funds and with the ward psychiatrist, complete and return to the PST the requisite Social Security forms to accomplish substitute payee status for that client. Upon request, ward psychiatrist will complete psychiatry reports for clients at NSH who are applying for SSI through the Placement Unit.

10. Upon condition of the 48-hour prior notification and at the agreed upon time of discharge of clients being directly placed and transported by the Placement Staff, Program V will have already obtained two weeks medication from hospital pharmacy, collected client's clothing and belongings from the ward, assisted the client with bathing, obtaining at least a change of clothing when he has none, etc., as necessary to be presentable for placement and will have prepared the discharge summary and authorization slip for leave and discharge funds, if applicable.

Signed,

Vernon Garrett MSW

Vernon Garrett, M.S.W.
Program Director

Barbara Bream

Barbara Bream, Chief
Placement Unit

INTERAGENCY AGREEMENT
BETWEEN REGIONAL CENTER OF THE EAST BAY AND ALAMEDA COUNTY DEPARTMENT OF MENTAL HEALTH
(July 1, 1978)

In order to provide the most appropriate services to individuals who have both Regional Center and mental health needs, Regional Center of the East Bay (hereafter referred to as RCEB) and Alameda County Mental Health Services (hereafter referred to as MHS) have agreed to the following procedures:

I. LIAISON:

In order to develop and maintain effective communication between agencies, liaisons have been identified.

If the liaisons for MHS and RCEB cannot reach agreement on the next course of action, the local MHS designee and the Medical Director (RCEB) should be consulted.

II. MENTAL DISORDER (M.D.)[3] AND DEVELOPMENTAL DISABILITY (D.D.)[3] SERVICES: EVALUATION AND DIAGNOSIS.

A. INDIVIDUAL UNKNOWN TO MHS AND RCEB:

The agency which first identifies the individual will perform an evaluation and make referral to the other agency if appropriate.

B. INDIVIDUAL KNOWN TO MHS BUT NOT RCEB:

If MHS feels such an individual could benefit from RCEB services, a referral will be made. There is no obligation on the part of RCEB to accept said individual if not D.D. and substantially handicapped (as determined by RCEB staff). If MHS is uncertain whether or not an individual has a D.D., MHS may obtain consultation from other county (e.g. psychological services, CCS, etc.) or community (e.g. schools, private psychologists) resources, or may request consultation from RCEB staff.[1] Consultation will usually be provided by an RCEB counselor, physician, and/or psychologist. In urgent cases (e.g. individuals on 72 hour hold in county hospitals), every attempt will be made by RCEB to provide this consultation within 48 hours (excluding weekends and RCEB holidays) of the request from MHS, but final determination of eligibility and disposition (if accepted as a RCEB client) will depend on the specific case. RCEB will keep records of such consultations, dates of involvement and disposition. Efforts should continue at a state level to establish an intermediate facility where individuals who require longer evaluation periods could reside.

C. INDIVIDUAL KNOWN TO RCEB BUT NOT MHS:

If RCEB feels such an individual could benefit from MHS services, a referral will be made. Such individuals may include known RCEB clients who develop a M.D. problem, newly diagnosed D.D. individuals who also have a M.D., or individuals deemed by RCEB staff not to have

a substantially handicapping D.D. but who are felt to have a M.D. RCEB may, at its discretion, refer a person to a private psychologist or psychiatrist for diagnostic evaluation and utilize third party or RCEB diagnostic funds. For diagnostic mental health services, the MHS shall be the last resort if the patient has no third party insurance, cannot afford private care, and it is inappropriate to utilize RCEB diagnostic funds in the private sector. If a referral is made to MHS for direct evaluation, RCEB will pay actual costs for psychiatric assessments done by MHS. "Indirect"[2] consultations from MHS will involve no charges to RCEB, family, or individual. The RCEB counselor who makes the referral to MHS for evaluation will provide follow up, including referral to a community or State resource if MHS feels the individual does not require its services.

RCEB and MHS will continue to consider an arrangement for MHS to provide weekly consultation to RCEB interdisciplinary staff regarding diagnostic issues, MHS services, and other matters.

D. All final diagnostic decisions with regard to the emotional disturbance of adults and minors referred to the MHS will rest with Deputy Local Mental Health Director or designee. All final diagnostic decisions with regard to the developmental disabilities of adults and minors will remain the responsibility of RCEB. MHS and RCEB will have appeal procedures available and will make this option known to families and/or individuals who are determined to be ineligible by the respective units. A patient or family who wishes to appeal the decision of MHS shall appeal to the Local Mental Health Director via the County's Patient's Rights Advocate.

III. M.D. AND D.D. SERVICES: AUTISM

The same criteria described above for diagnosis of a D.D. or M.D. apply to Autism. Please also refer to attachment #1.

IV. M.D. AND D.D. SERVICES: CASE MANAGEMENT

Within the priorities established by Alameda County MHS in providing services to the more seriously and chronically mentally disabled persons with a history of psychiatric hospitalization or at high risk of hospitalization, treatment planning for the emotional disturbances of the developmentally disabled person will be the responsibility of MHS for those individuals accepted as MHS patients.

RCEB will continue to exercise its responsibilities for the developmental disabilities of the client throughout the duration of the emotional disturbance as necessary. Upon the remission or stabilization of said emotional disturbance in the D.D. person, RCEB will assume responsibility for continuation of case management for the person, unless this is the provence of another agency (e.g. Department of Social Services, Probation, etc.), in which case RCEB will provide consultation as necessary.

For any RCEB client receiving MHS services, there should be at least monthly telephone and/or written contact between the RCEB counselor (or other appropriate staff member) and the MHS person involved with that client. This contact shall be recorded in the patient's mental health chart.

V. M.D. AND D.D. SERVICES: TREATMENT

A. OUTPATIENT:

MHS or its appropriate contractors will provide psychiatric treatment for D.D. persons (and families) who are experiencing chronic psychotic symptoms or other severe emotional disturbances, unless the individual has and prefers to use third party insurance.

MHS will also provide indirect and/or direct consultation to RCEB staff (see II C above) at RCEB's request for clients suffering severe emotional problems or psychosis. There will be no charge for indirect consultation. Direct consultation will be financed by third party payments, if available, by family funds according to UMDAP or by RCEB funds in selected cases

Except under rare circumstances, and as previously agreed upon by RCEB Purchase of Service (POS) Committee, RCEB funds will not be used for psychiatric, psychological, or counseling <u>therapy</u>.

B. <u>INPATIENT</u>:

MHS will provide short-term psychiatric hospitalization (or other inpatient service) for D.D. individuals who appear to be experiencing acute psychotic episodes utilizing the same admission criteria that apply to the general population. It should be noted that these criteria are highly selective and do not result in all referrals receiving acute inpatient care.

VI. M.D. AND D.D. SERVICES AND PLACEMENT

On individual clients with both M.D. and D.D. needs, MHS and RCEB will discuss whether a M.D. or D.D. residential facility is most appropriate, and the pertinent agency will assist the individual (family) in arranging admission (i.e. community facility or State Hospital). In those cases where a Lanterman-Petris-Short-Act conservator has been appointed, the conservator (rather than MHS) has the responsibility for facilitating and approving the placement. RCEB (or DPSS or Probation, etc.) will retain case management responsibility regarding the Developmental Disability regardless of residential facility. If the person is admitted to a M.D. facility, RCEB-MHS conferences should be held at least semiannually to discuss the individual's progress. If no suitable program is available to MHS, MHS will recommend alternative treatment planning to RCEB who will attempt to obtain suitable alternative placement.

If the individual is admitted to a D.D. residential facility, MHS should maintain its involvement as necessary and appropriate in those cases with active mental health records.

Liaisons from RCEB and MHS (Alameda County Placement Unit) will meet to discuss issues regarding placement, especially for those individuals with both a M.D. and D.D. RCEB will initiate this process with Chief of Alameda County Placement Unit.

VII HOSPITALS

A. In the event that transfer from a D.D. State Hospital Program to a M.D. State Hospital Program is anticipated, the Chief of Alameda County Placement Unit shall be notified and involved in this process.

B. Napa: Please see attachment #2 regarding Autistic Individuals. MHS will maintain responsibility for hospitalization of acutely psychotic individuals regardless of D.D. status utilizing the same criteria as for the general population. If the individual is already an RCEB client, RCEB should be notified as soon as possible. For those suspected D.D. individuals not known to RCEB, please refer to section II-B. If Napa staff or the Alameda County Placement Unit feel that an individual in an M.D. unit has a substantially handicapping D.D., referral should be made to RCEB Intake Worker. This especially applies to individuals who may need a D.D. program in a State Hospital or in the community. D.D. individuals at Napa may develop acute psychiatric conditions and will have M.D. programs and services available as appropriate.

C. Stockton: Please see attachment #2.

D. MHS may also be asked by RCEB to provide consultation (especially indirect) on hospital D.D. residents being considered for community placement. The MHS liaison for this service will be the Supervising Placement Unit worker at Napa State Hospital.

E. MHS may request consultation from RCEB regarding possible D.D. services and/or placements for individuals being discharged from M.D. facilities (e.g. State or community hospital or other locked M.D. facilities). The RCEB liaison for this service will be Laurel Kay.

VIII DETERMINATION OF INVOLUNTARY STATUS

A. Whenever a D.D. person becomes gravely disabled by virtue of M.D. and it appears long term psychiatric treatment will be required, MHS will initiate conservatorship procedures in accordance with the Lanterman Petris Short Act.

B. When it is determined, by appropriate psychiatric evaluation, that the D.D. person is no longer gravely disabled by virtue of M.D., RCEB will assume appropriate responsibility for the D.D. person under the RCEB mandate.

C. RCEB will follow accepted local and state guidelines according to private conservatorship in advising individuals and families regarding D.D. conservatorship and guardianship, including guardianship by the Director, DOH.

D. Whenever a D.D. person is unwilling to accept treatment, management, or placement, RCEB may recommend that a Superior Court declare the individual dangerous to self and others. This will be done via the office of the district attorney (or parents, probation officer, youth authority, etc.).

RCEB may petition the Court directly in specific cases where an individual is already in a state hospital D.D. program and becomes unwilling to accept needed treatment, management or placement. Such cases will be handled according to W & I Code 6513-6519.

IX JUSTICE SYSTEM REFERRALS:

A. M.D.: MHS (adult or child services) may request RCEB consultation if MHS feels a charged offender is substantially handicapped from a D.D. and requires RCEB services, or if consultation is felt necessary in order to assist MHS management of the individual.

B. D.D.: RCEB may request direct or indirect consultation from MHS if a RCEB client who is charged with a legal offense is felt to require M.D. services. Consultation may also be requested in 1370.1 cases (non-RCEB clients who are referred to RCEB by the court for evaluation of a D.D.). This specifically pertains to those persons whom RCEB feels may have a significant emotional or psychotic problem. There will be no charge for indirect consultation.

X. INSERVICE TRAINING

A. RCEB and MHS will provide reciprocal inservice training sessions bimonthly, as needed, regarding the agency itself and/or topics relating to D.D. and M.D. These sessions will be the responsibility of the Alameda County MHS Training Office and RCEB Medical Director.

B. RCEB and MHS will each send a representative to the monthly D.D. Council Case Committee for discussion of difficult case situations. The MHS's liaison persons involved in the cases or the adult/child liaison who should have been involved shall be the MHS representative.

C. RCEB will send a representative to the quarterly meetings of the Chiefs of Childrens' Services.

XI. This agreement shall become effective upon signature of both parties and shall be reviewed annually to determine continued need. Either party may cancel the agreement be sending 90 days written notice of such intent to the other party.

Susan Mandel, Ph.D.
Alameda County
Department of Mental Health

July 1, 1978
Date

Claire P. Hinshaw
Regional Center of the East Bay

FOOTNOTES

1. RCEB consultation can only be provided after written permission from the parent (if individual is a minor), guardian, or individual (if 18 years or over and no guardian).

2. "Direct" MHS consultation: Involves contact and/or interview with individual. "Indirect" MHS consultation: Involves review of record and discussion with RCEB but no visual or verbal contact with person.

3. Definitions

   A) "Developmental Disability" means a disability which originates before an individual attains age 18, continues, or can be expected to continue indefinitely, and constitutes a substantial handicap for such individual. As defined by the Director of Health, in consultation with the Superintendent of Public Instruction, this term shall include mental retardation, cerebral palsy, epilepsy, and autism. This term shall also include handicapping conditions found to be closely related to mental retardation or to require treatment similar to that required for mentally retarded individuals, but shall not include oher handicapping conditions that are solely physical in nature".

   "Substantially handicapped describes a developmentally disabled individual whose needs cannot be met adequately from participating in and benefiting from those social, educational, vocational, recreational, medical, or other sources which generally are expected to be available to other non-handicapped individuals in the community."

   B) There is not a legal definition of mental disability, however, since there are constraints on resources that the public mental health sector has available and also a clear state mandate with regard to the development of non-hospital based community alternatives for the treatment of the more seriously and chronically disabled population, Alameda County has established the following guidelines:

   PRIORITY OF PATIENTS TO BE SERVED:

   1. Those persons, adult and child, with a history of psychiatric hospitalization at either state, local public or private facilities.

   2. Those persons, adult or child, never hospitalized but at risk of requiring such care if they do not receive services.

   REFERRALS:

   Persons referred from any psychiatric hospital, the Placement Unit, Psychiatric Emergency Services or those defined as a crisis case by an outpatient service shall receive an initial appointment and interview within five working days of the referral.

ATTACHMENT #1

In compliance with State Department of Health Policy, Alameda County Mental Health Services and Regional Center of the East Bay have agreed to the following procedures regarding State Hospitalization of Autistic persons.

I. All new admissions to the Autistic Program at Napa State Hospital from Alameda County must be authorized by the Regional Center of the East Bay.

II. The accepted definition of Autism follows: "A syndrome appearing before the age of three years of life, which is characterized by extreme withdrawal, language disturbance, inability to form affective ties, frequent lack of responsiveness to other people, monotonously repetitive motor behaviors, inappropriate response to external stimuli, and an obsessive urge for the maintenance of sameness. Many, but not all children may be severely impaired in inherent intellectual capacities".

III. Napa State Hospital now operates a separate Program for Autistic persons that is divided into three units, one for the under twelve year old population, another for twelve to eighteen year olds, and a third for the over eighteen year old group.

IV. If Mental Health now has active cases for referral to the Autistic Program at Napa, these patients shall be referred to Regional Center of the East Bay for screening. Contact Intake worker at 415-451-7232.

Mental Health will retain its involvement with active cases referred (either in Community or State Hospital) until Regional Center eligibility is determined. Mental Health involvement may continue to be appropriate in some cases being managed by Regional Center of the East Bay.

V. If Mental Health Services receives requests for screening Autistic individuals for State Hospital Programs who are not yet patients, these persons are to be referred to Regional Center of the East Bay for screening. Contact Intake worker at 415-451-7232.

VI. The Regional Center of the East Bay may, after its screening, determine that the referred individual does not fit within the accepted definition of Autism and thus is not eligible for Regional Center services or State Hospitalization in the Autistic Program. The Regional Center will so notify the patient and family and will refer the family back to Mental Health Services for further treatment or screening for an M.D. State Hospital Program. Mental Health will review this case and accept it if clinically indicated.

The Regional Center of the East Bay may, after its screening, determine that State Hospital care is not the most appropriate intervention for a particular Autistic person and, while maintaining case management responsibility, may refer to Mental Health Services for outpatient service, acute adult inpatient service, children's day treatment services, etc. Mental Health will review this case and accept it for treatment if clinically indicated.

ATTACHMENT #1 CONTINUED:

VII. If any problems arise in the referral of these patients from one system to the other, Mental Health clinicians shall contact the appropriate Mental Health liaison (to be identified at a later date), and Regional Center staff shall contact the Medical Director, Regional Center of the East Bay.

VIII Those Alameda County patients now at Napa State Hospital who have been transferred to the Autistic Program (Program XV) will be reviewed by the Regional Center of the East Bay to determine whether or not they meet the diagnostic criteria for Regional Center clients. If the patient meets these criteria, Regional Center of the East Bay will assume case management responsibility and the patients will be part of the Developmentally Disabled Program rather than Mentally Disordered Program. Those patients who do not meet these criteria may, at the discretion of the Local Mental Health Program, remain in the Autistic Program, but will then be charged to the County's State Hospital day allocation.

ATTACHMENT #2

STOCKTON STATE HOSPITAL EXCEPTIONAL YOUNG ADULT (E.Y.A.) PROGRAM:

I. The Stockton State Hospital E.Y.A. Program is for Mentally Retarded Young Adults, ages 14-24 years, with significant behavior problems.

II. It is possible for both Mental Health programs and the Regional Center to refer patients to this program. If Mental Health refers the patient, the State Hospital Days utilized are part of the referring county's State Hospital allocation. If Regional Center refers one of its clients, the hospital days are not part of the Short/Doyle system in any way. It is also possible for Mental Health Services to refer a patient and subsequently have the patient accepted as a Regional Center client in which case funding responsibility will be shifted to the Regional Center after the patient has become a client.

III. In the event that a Mental Health clinician has a patient who may be appropriate for the E.Y.A. Program contact should be made with Regional Center of the East Bay (451-7232) to ascertain whether or not the patient is a Regional Center client. If he is a Regional Center client, the Regional Center may agree to refer to the E.Y.A. or to another Developmentally Disabled State Hospital Program. If he is not a Regional Center client and State Hospital care is indicated, discussions should be held with Laurel Kay at 798-3001 to discuss this particular patient's needs and planning for him. If State Hospital care is indicated, a referral to Regional Center should be made.

IV. If there are time constraints and Mental Health believes that the patient should be referred directly to the E.Y.A. Program, the following procedures should be utilized:

a) Final authorization for State Hospital admission is vested in J. L. York, M.D. for patients eighteen years of age and older and the Mental Health liaison (to be determined at a later date) for patients under the age of eighteen.

b) Barbara Schreiber, the Community Liaison Worker for Stockton State Hospital, should be contacted at (209) 948-7111 to ascertain the probable appropriateness of a referral to the E.Y.A. Program. If, on the basis of the verbal description, Ms. Schreiber believes the referral to be appropriate, then a Resident Evaluation Form is to be completed in accordance with the instruction booklet and that information, together with recent psychological, medical, and social information, is to be mailed to Stockton State Hospital.

The review porcess at Stockton State Hospital for the E.A. Program takes approximately five working days after receipt of the written information.

V. If a resident in this program is an RCEB client and unknown to MHS, and RCEB feels that MHS involvement is needed, the RCEB counselor should contact the appropriate MHS liaison.

CONSERVATOR - MENTAL HEALTH AGREEMENT*

THIS AGREEMENT, made and entered into this ___ day of _____, by and between the ALAMEDA COUNTY HEALTH CARE SERVICES AGENCY MENTAL HEALTH SERVICE, and the ALAMEDA COUNTY CORONER - PUBLIC ADMINISTRATOR DEPARTMENT in order to satisfy the provisions of Section 5609.5 of the California Welfare and Institutions Code which requires a written agreement between Health Care Services Agency and any other department providing services under the Short/Doyle Act.

WITNESSETH

Pursuant to the Lanterman-Petris Short Act (California Welfare and Institutions Code 5000 et seq.) the Board of Supervisors appointed the Coroner - Public Administrator to act as the Lanterman-Petris Short Act (LPS) Conservator and Conservatorship Investigator. The LPS Conservator and Conservatorship Investigator, hereinafter called the Conservator's Office, conducts conservatorship investigations as described by the LPS Act, and in those cases where the Conservator has been appointed temporary or permanent conservator administers conservatorships of the person or estate or person and estate.

CONSERVATOR TO PROVIDE

1. INVESTIGATION AND REPORT

The Conservator's Office shall provide conservatorship investigations from the time a recommendation is received from an appropriate source until:

a. A Judge hearing a petition for permanent conservatorship denies, or approves the petition; or,

b. Until the Conservator's Office decides that neither the temporary nor permanent conservatorship are necessary or appropriate, at which time the case is dropped, and,

c. The temporary conservatorship if established is allowed to expire.

In the event that the Conservator drops the case, and prior to that action, the responsible Mental Health staff will be notified. The name and location of the Mental Health staff responsible for this patient will be stated in the conservatorship letter.

In the event that the Conservator's Office concurs with the recommendation for conservatorship, and determines that it is in the best interest of the patient to establish a temporary conservatorship, the conservator shall petition the Superior Court using as a basis for the petition the recommendation for conservatorship.

* This agreement is currently being completed and signed by the Conservator's Office and Mental Health.

In the event that permanent conservatorship will be recommended to the Court, the Conservator's Office will submit a written report to the Court before the hearing on the petition to establish permanent conservatorship. The report shall satisfy the requirements set forth in Sections 5354 et seq. of the Welfare and Institutions Code.

2. CONSERVATORSHIP OF PERSON

When the Conservator's Office is appointed temporary or permanent conservator of the person, the duties of the conservator will include, but will not necessarily be limited to the following:

a. Sign admission forms and consent to treatment forms at the time of admission to facilitate hospitalizations or admissions to other facilities for treatment of mental and physical disorders as authorized by the Court.

b. Monitor the care and progress of the conservatee regardless of the location of the conservatee by making contact with the conservatee periodically as indicated. The conservator will provide the responsible Mental Health Staff, either the staff person named in the conservatorship letter or placement unit staff if the placement is out of county, with information regarding changes in the patient's condition, legal status or appropriateness of the placement. When it is apparent that the placement is no longer appropriate, the conservator will coordinate, in consultation with Mental Health Services, a transfer to a suitable placement insofar as it is possible. Because of the authority vested in the conservator with regard to placement, the conservator reserves the right to approve or deny proposed placement plans for the conservatee. Furthermore, the conservator recognizes the need of Mental Health Services to reduce State hospital utilization and will cooperate with the Placement Unit in exploring all local alternatives.

c. Coordinate or initiate referrals to service agencies for the benefit of the conservatee when the need for services is apparent.

3. CONSERVATORSHIP OF ESTATE

If the Conservator's Office determines that a proposed conservatee requires estate management, the Conservator's Office shall petition to become the conservator of the estate. In this capacity, the Conservator's Office will protect the estate against loss, marshall assets, and make application to the appropriate agencies for financial benefits and services for which the conservatee is eligible and disperse funds to patient as indicated.

4. RENEWAL OF CONSERVATORSHIP

The Conservator's Office will provide the services necessary to renew conservatorships in those cases where the Conservator's Office has been appointed, and renewal is being recommended to the Court. The Conservator's Office will also advise private LPS conservator's during

the renewal process when such assistance is requested. The conservator will notify the responsible Mental Health Staff prior to expiration date and discuss the appropriateness of a renewal.

MENTAL HEALTH TO PROVIDE

1. INPATIENT

   a. Provide the conservator with an application form requesting conservatorship, affidavits as required by law, and a letter documenting the need. The name of the staff person responsible for this patient will be indicated in the letter.

   b. Make information and records available to the Conservator's Office for purposes of facilitating the conservatorship (Welfare and Institutions Code Section 5354) and if needed, provide testimony to establish or renew conservatorship.

   c. Notify the conservator when a conservatee is admitted to Emergency or Inpatient Services. The Conservator will then be responsible for signing the admission forms.

2. OUTPATIENT

   a. Mental Health Staff will collaborate with the Conservatorship Office regarding the renewal of the conservatorship by providing appropriate information to investigator and when necessary, providing expert testimony to the Court.

   b. In situations where involuntary acute hospitalizations (Section 5150 and 5250) would be to the detriment of the patient, and placement into a locked skilled nursing facility or other locked treatment setting is desired, a direct referral by the appropriate Mental Health Center Staff for Conservatorship may be made to the Conservator's Office, using the inpatient procedures in 1A and 1B above. Examples are, minors over the age of 14 referred PGC, an adult in an unlocked community treatment facility (i.e., Laurel House), or a frail elderly person in a skilled nursing facility. In these cases, Mental Health Staff assumes responsibility for arranging the transfer to the locked setting, and for providing testimony for the Conservatorship hearing.

3. PLACEMENT

   a. Mental Health Placement Staff will consult with conservator prior to the initiation of the placement process.

   b. Mental Health Placement Staff will notify the conservator when placement is about to occur. The actual placement is the responsibility of the placement unit.

BUDGET FOR SERVICES/ANNUAL BUDGET

The Conservator's Office shall submit to the Director of the Health Care Services Agency on or before January of each year a proposed budget for the next fiscal year. The budget shall include maintenance of established conservatorships and renewals of conservatorships.

Discussions shall take place between the appropriate agencies until a budget is agreed upon. The amount agreed upon shall then become part of this contract, and the Conservator's Office shall agree to operate within the limits of the budget, barring unmanageable changes in caseload or procedures.

RECORDS, PAYMENTS, AND FEES

The Conservator's Office shall maintain records and information upon which costs are determined and charged.

Commissions or fees awarded by the Court to the Conservator's Office from the estates of LPS conservatees shall be deducted from costs claimed by the Conservator's Office.

The actual costs for the conservatorship program as described above shall be billed by the Conservator's Office. In addition, monthly reports will be furnished which indicate the number of referrals received, units of service, and cost per investigation or referral for the past month.

AMENDMENTS AND TERMINATION

1. Any matters discussed herein may be amended when there is mutual consent of all the parties. These amendments will not affect the remainder of the agreement.

2. This agreement may be terminated at any time by notices in writing delivered by one party to the other not less than sixty (60) days prior to such termination.

TERM OF THE AGREEMENT

This agreement shall become effective on
and shall terminate on

In witness whereof, the parties hereto have caused this agreement to be executed on the date written above.

HEALTH CARE SERVICES AGENCY

By _____

CORONER-PUBLIC ADMINISTRATOR-
PUBLIC GUARDIAN-CONSERVATOR

By _____

COUNTY COUNSEL

By _____

SERVICE AGREEMENT BETWEEN

ALAMEDA COUNTY MENTAL HEALTH SERVICES

AND OFFICE OF CONTINUING CARE,

STATE DEPARTMENT OF MENTAL HEALTH

The following is a service agreement between Alameda County Mental Health Services and the Office of Continuing Care, State Department of Mental Health. The intent of this Agreement is to set forth mutual expectations by which the State and County Mental Health Services will work together to serve the mentally disabled of Alameda County. It will be effective for fiscal year 1979-80, with each party retaining the option to initiate a modification of this Agreement should circumstances dictate. Such requests should be written and directed to either the Office of Continuing Care Area Supervisor or the Director of Alameda County Mental Health Services, or her designee. Within one month of receipt of such request, a meeting between both parties shall be held to review the request and make any adjustments deemed necessary. All such modifications shall be written, signed, and appended to this Agreement.

This Agreement recognizes that the Office of Continuing Care is an administrative entity within the State Department of Mental Health which retains sole authority as to other vendors of service for the direct administration and supervision of its program and staff.

Both parties agree to share information and to discuss, ahead of time, any decisions or changes that potentially effect the working relationships of either service. Whenever possible, disagreements will be handled on first-line level of management. If no agreement can be reached, the Area Supervisor and Director of Mental Health, or her designee, will be available to participate in discussions to resolve the difference.

No services provided by Office of Continuing Care staff will be denied because of any County residency requirements. Procedures for client identification will be in compliance with State and Federal guidelines. Clients will be referred and appropriate information shared in accordance with procedures of the County Referral Confirmation System. Contractor shall maintain the confidentiality of all information and records obtained in the course of providing services under this Agreement. Such information and records may be disclosed only in accordance with the provisions of Section 5328 of the Welfare and Institutions Code.

The process provided for under State and Federal regulations will be adhered to by the Office of Continuing Care for persons requesting a fair hearing with reference to the acceptance or denial of services or the quality of services provided.

Program review shall be conducted through the means of quarterly progress reports, and periodic on-site visits, record review, and conferences, as well as by any other methods deemed necessary by the Director of Mental Health, or her designee, and/or Office of Continuing Care supervisory staff.

Services provided under this Agreement shall involve two main areas. The first is Case Management and Placement, and the Office of Continuing Care shall designate one SPSW I, five and one-half PSW's, and one Office Assistant, to comprise a distinct unit to work with the Alameda County Specialized Services Unit. This Office of Continuing Care Unit shall work with the Specialized Services Unit so as to provide the residents of Alameda County with one integrated and centralized Facility Liaison, Placement, and Case Management system.

The December 6, 1978, document, "Proposal for Specialized Services (Case Management)", will provide the basic framework for services to be provided. The above document also sets forth the procedures for client identification and referral and expected work standards (see Page 5, Flow Chart for Case Management Client, and Page 4, addendum outlining goals, objectives, plan for implementation, and standards).

The caseload for a full-time PSW Case Manager will be a minimum of 25 ongoing clients. There will also be Placement responsibility from Napa State Hospital. With the exception of Case Management clients, no more than one and one-half full-time PSW equivalents will be used for non-Case Management Placement activities.

For the sake of uniformity, the Office of Continuing Care will use the special recording system being developed by the County. In addition, State mandated statistical, Residential Care Fund and Information Practices Documents will be used by State workers.

The Office of Continuing Care PSW's assigned to Case Management services will be granted authority to utilize Section 5150 of the State Welfare and Institutions Code by the Local Director of Mental Health Services.

The Office of Continuing Care will develop a money-management system for clients who require and are desirous of this service.

The second area covered by this Agreement concerns outpatient services, and shall consist of the remainder of the Office of Continuing Care supervisory and line staff--two SPSW I's, eight PSW's, and two Office Assistants. This staff shall comprise a second distinct administrative unit, which will be centrally administered and shall serve all catchment areas of Alameda County. Primary functions of this Office of Continuing Care Unit shall include:

1) Provide direct, indirect, and consultative services to residents and operators of identified Residential Care Facilities (RCF's) for the mentally disordered in Alameda County. RCF's assigned to Office of Continuing Care staff are listed in the 1979 County RCF Plan, and services provided shall be in accordance with the principles and standards set forth in that plan (see attached).

2) Provide direct, indirect, and consultative services to clients and program staff of Creative Living Centers in Fremont, Hayward, and Oakland. In addition, will provide one staff/two days per week program involvement, to Eden Intermediate Day Care Program. Office of Continuing Care staff may work in conjunction with Social Service Bureau of the East Bay, Inc., and the Region/Center Mental Health Services to:

a) Assist with the development of the Socialization Activity Program.

b) Open cases or refer to an appropriate service, participants who require further treatment.

c) Assist with activity and recreational program for the participants.

d) Assist with volunteer participation relative to Socialization Programs.

3) Provide development of active supervision of County-wide volunteer program. The SPSW I, in agreement with the appropriate Mental Health Director, or his/her designee, will designate staff to recruit, screen, supervise, and train volunteers (in coordination with the Social Service Bureau, when appropriate, the Region/ Center Mental Health Services, and HPIS volunteer program), to assist in social rehabilitation activities. Volunteers may assist with:

a) Group activities at Creative Living Centers or community care facilities.

b) Visiting selected individuals in their own homes or community care facilities.

c) Clerical work.

d) Public relations.

e) Transportation.

4) Provide placement and follow-up services for four to five children placed through MMPI funds.

To facilitate coordination, sharing of information, and integration of programs, SPSW I of the Office of Continuing Care will designate individual staff members to attend County or contract outpatient services staff meetings (e.g., West Oakland and Berkeley) in each of the catchment areas of Alameda County. Minimum contact should involve attendance at one staff meeting per month.

Susan Mandel, Ph.D.
Director of Mental Health
County of Alameda

Robert Goulet, M.S.W.
Area Supervisor
Office of Continuing Care

Robert Cacic
Community Program Analyst
State Department of Mental Health

DK:klr
6/29/79

(Note: The following is the completed portion of the agreement between the State Department of Mental Health, Office of Continuing Care, and Alameda County Special Services Unit. An additional section detailing areas of responsibility for residential and day programs is in the process of being developed. This will be forwarded upon completion.)

SERVICE AGREEMENT BETWEEN STATE DEPARTMENT OF MENTAL HEALTH AND ALAMEDA COUNTY SPECIAL SERVICES UNIT

I. INTRODUCTION

The intent of this agreement is to set forth mutual expectations by which the State and County will work together to assist mentally disabled persons who require placement or case management services.

II. This agreement will be effective for the balance of the fiscal year 1978-79 and fully implemented within one month of signing. Cancellation or modification may occur at the time a more comprehensive service contract is established or State or County system changes preclude continuance.

III. ADMINISTRATION

This agreement recognizes that the Office of Continuing Care is an administrative entity within the State Department of Mental Health which retains sole authority as to other vendors of service for the direct administration and supervision of its program and staff. It is the intention of the Office of Continuing Care to maintain a cooperative non-obstructive working relationship. Every effort will be made to resolve potential disagreements at the first line level of management. It is understood that as the new County unit develops, decisions potentially affecting the Office of Continuing Care staff will be discussed with the OCC Supervisor. If no agreement can be reached, the Area Supervisor, OCC Supervisor, Chief of the Special Services Unit and the Director of Special Services will be available to participate in discussions to resolve differences.

IV. STAFFING

The Office of Continuing Care will delegate one SPSW I, five and one-half PSW's and one Office Assistant to comprise a distinct unit to work exclusively with the Specialized Services team.

V. HOUSEKEEPING

The Office of Continuing Care will provide State staff, office space, supplies, phone and on-duty coverage between 8:00 a.m. and 5:00 p.m. on normal working days.

VI. RESIDENCY

Services will not be denied because of any County residency requirements.

VII. SERVICES

The 12/06/78 document, "Proposal for Specialized Services (Case Management)" will provide the basic framework for services to be provided. However, there will be a temporary mix agreed upon by SPSW I and Special Services Chief.

The above document also sets forth the procedures for client identification and referral and expected work standards (see page 5, Flow Chart for Case Management Client, and page 4 addendum outlining goals, objectives, plan for implementation and standards).

VIII. WORKLOAD EXPECTATIONS

The caseload for a full-time PSW case manager will be a minimum of 25 ongoing clients. There will also be placement responsibility from Napa State Hospital. With the exception of Case Management Clients, no more than oneand one-half full-time PSW equivalents will be used for non-case management placement activities.

IX. RECORDS

For the sake of uniformity, OCC will use the special recording system being developed by the County. In addition, State mandated statistical, Title XX, Residential Care Fund and Information Practices Act Documents will be used by State workers.

X. INVOLUNTARY HOSPITALIZATION

OCC PSW's assigned to Case Management Services will be granted authority to utilize Section 5150 of the State Welfare and Institution Code by the local Director of Mental Health Services.

XI. SUBSTITUTE PAYEE

OCC will develop a money management system for clients who require and are desirous of this service.

Robert Casic
DATE

Robert Casic
Community Program Analyst
State Department of Mental Health

David J Kears 3/12/79
DATE

David Kears
Director of Special Services
Alameda County Mental Health Services

3/14/79
DATE

Jack Tanenbaum
Area Supervisor
State Department of Mental Health

AFFIRMATIVE ACTION PLAN

Progress Statement

Alameda County Mental Health Services, as a part of the Alameda County Health Care Services Agency, must develop and implement an affirmative action plan in concert with the plan of the Agency. In October, 1977, the Agency published the "Statement of Policies and Procedures of the Mental Health Plan" (available upon request). Based on this statement, Alameda County Mental Health Services developed a preliminary affirmative action plan for implementation within the Mental Health Services.

Portions of this statement have been implemented, either partially or totally. These portions include:

- Definition of service area and target populations
- Data and reporting of population descriptions of service areas
- Service site staffing pattern analysis
- Translation of critical forms
- Designation of bilingual/bicultural positions

Most of the above items are addressed and/or included in this Short-Doyle Plan.

The Health Care Agency's Affirmative Action Officer recently announced that a more complete and detailed affirmative action plan for the Agency and its departments will be published by July, 1979. Upon receipt of this Plan, Alameda County Mental Health Services will update their affirmative action plan and design an affirmative action program that assures qualified candidates' positions without discrimination because of:

- Race
- Religion
- Age
- Handicaps
- Color
- Sex
- National Origin

The Local Mental Health Director or her designee will be responsible for the development and implementation of this Plan. This Plan shall address at least the following:

- Specific goals and objectives applicable to Mental Health Services as a whole as well as service site specific
- Data collection and reporting standards
- Appropriate designation of bilingual/bicultural positions

- Recruitment policies and guidelines
- Training programs to be offered
- Specialized efforts to recruit minority students and staff
- Transfer policy
- An accountability mechanism to ensure progress toward goal attainment
- Process whereby Plan will be updated and improved on a regular basis
- Appropriate staff and Mental Health Advisory Board involvement in the development of the Plan
- Recruit and train persons sensitive to needs of underserved population, i.e., elderly, sexual minority

This Plan will be completed by January, 1980, and will be forwarded to the State Department of Mental Health at that time.

MENTAL HEALTH ADVISORY BOARD MINORITY COMPOSITION

The following delineates the Alameda County Mental Health Advisory Board's current status with relationship to standards for advisory boards (Welfare & Institutions Code: Article 1340, Composition).

Requirement:

1. The composition of the Mental Health Advisory Board shall reflect the minority population found in the county.

2. Each county shall describe in the Plan efforts being made to place presently unrepresented and underrepresented minority group members on the advisory board, including a timetable to achieve equitable representation.

   Findings:

   Our current Board's profile is as follows:

Caucasian	9
Black	5
Spanish Speaking/Surname	1
Asian	1
Native American	0
Other	0
Vacancy	1

   In terms of underrepresentation, the Mental Health Advisory Board has no Native American member.

3. Each county shall indicate in the County Mental Health Plan the total number of current board members and their minority affiliation, if any.

   Findings:

Members	Ethnic Group
Marjorie Carey	Caucasian
Ramona Davis	Black
Hilton de Selm	Caucasian
Leona Florida	Black
Barbara Graves	Caucasian
Gene Hazzard	Black
Jay Mahler	Caucasian
Lina McPeake	Caucasian
Tom Mitchell	Black
Valerie Raymond	Caucasian
Astrid Rusquellas	Spanish Speaking/Surname
Gail Steele	Caucasian

Findings (cont.):

Members	Ethnic Group
Marion Tinloy	Asian
Sandy Turner	Caucasian
Ruth Willets	Caucasian
Marjorie Woods	Black

OVERVIEW OF THE PROPOSED EXPANDED COMMUNITY RESIDENTIAL TREATMENT SYSTEM (AB 3052)

With the addition or expansion of proposed Community Residential Treatment System (CRTS) programs, Alameda County hopes to fulfill the promise of providing its residents its real and effective alternatives to institutionalization. By focusing on non-medical models and encouraging as much local participation in the design and control of these programs as possible, the County hopes to avoid the stigmatization that is so often associated with traditional programs, and to promote programs that are truly sensitive to the myriad of ethnic and cultural differences that exist within the community.

The development of new services such as the crisis home and the long-term residential facility will serve to broaden the scope of our programs and enable us to provide residential treatment to heretofore ignored populations. The expansion and augmentation of other services, such as our Social Rehabilitation Facilities, Creative Living Center(s) (CLC) and Satellite homes, will allow them to truly provide a supportive yet aggressive interactive approach to individuals who might otherwise be forgotten or given up on. The development of special services such as a day treatment program for adolescents and ethnic minorities will serve as the first step in a commitment to provide culturally and ethnically responsive services to underserved minorities and to serve an adolescent population that has been too frequently relegated to juvenile hall or Napa State Hospital (NSH). Plans for residential programs to complement these last two services will be forthcoming as both programs mature. A special effort to encourage ethnic minority groups to respond to the Request for Proposal for the crisis home and long-term residential facility will also be made.

The proposed services will be tied together through a combined system of case management and facility liaisons. The case management component allows the County to provide the most aggressive services to those individuals most at risk for re-institutionalization, and to have the same staff member follow those individuals over a period of time, independent of service sites or facilities. The expanded facility liaison system will enable the program to link each CRTS element to other parts of the County and Contract Mental Health system, as well as providing the protection of overlapping coverage and accountability. This is particularly important given the high vulnerability of individuals as they move from one facility to another.

A children's case management and facility liaison service is now in the process of development, and will support the existing adolescent day treatment program. This unit will be administratively responsive to one of Alameda County's two children's center directors, but will be coordinated both in design and daily operation with the Adult Services. All youth referred to our proposed adolescent day treatment program will be assigned a case manager who will also assume facility liaison responsibility. A protocol will be developed regarding the transfer of responsibility between the two case management services as individuals move from youth to adulthood.

The CRTS programs will be evaluated both as individual elements with specific goals and objectives and as a system. A proposal for the evaluation of the entire CRTS system is submitted here, with individual evaluative components incorporated into each proposal. Time constraints have slowed the interfacing of both components at this time.

Procedures for collecting data will be consistent with laws of confidentiality, and sensitivity to the autonomy and privacy of each program will be maintained.

The Crisis House, Long-Term Residential Facility and the Specialized Services will be contracted via a Request for Proposal process. A Day Treatment component for adolescents will be contracted to an existing provider of proven effectiveness. The County of Alameda itself does not plan to operate any of the new services under this proposal.

PROPOSITION 13 IMPACT

Mental Health Services

INPATIENT SERVICES - Highland

Despite serious recruitment problems, primarily due to Proposition 13, we were able to return the acute psychiatric bed census back to 40 in November. We were able to do this by recruiting a limited number of nursing staff, by continuing to have the nursing staff work overtime, and by relying heavily on per diem staffing. We continue to have a significant number of psychogeriatric patients in the acute beds as there still are insufficient programs for these patients (approximately 8 to 10 of the 40 acute beds are used for psychogeriatric patients on any one day). There continues to be a critical overall shortage of locked hospital beds; and, therefore, patients are still being sent, inappropriately, to the State Hospital in the absence of any other appropriate alternative facility.

Our nursing staff may be planning some form of work reduction in February if they do not get a salary increase. Should this occur, we will have to reduce beds or close a unit at Highland.

NAPA STATE HOSPITAL

The census at Napa continues to be higher than last year. This is related directly to:

1. The fact that psychogeriatric patients occupy 8 to 10 of our local acute beds on any one day.

2. Adolescent patients occupy 4 to 6 local acute beds on any one day (alternative resources have all but disappeared for this population).

3. Female criminal justice patients are now occupying 3 to 4 of our local acute beds on any one day.

The average length of stay for these three categories of patients is in excess of two weeks and is significantly affecting our acute bed utilization.

PSYCHIATRIC EMERGENCY SERVICE

General nursing staff shortages continue to impact on these sights. As more acutely disturbed people are continuing to seek service and we continue to have insufficient private and public resources available to them, it is not unusual for patients to remain for up to 24 hours in the Psychiatric Emergency Service waiting for a bed to become available.

CRIMINAL JUSTICE MENTAL HEALTH SERVICES - Inpatient Care

The inpatient unit is kept staffed at all times since even the State Hospital will not take the in-custody client. The outpatient aftercare program personnel are maintaining the same level of services despite loss of staff and serious recruitment problems.

NAPA STATE HOSPITAL ADMISSIONS - Children and Adolescents

The census of Alameda County patients under 18 years at Napa State Hospital and Stockton State Hospital (EYA Program) has remained between 40-45 since July, which is higher than pre-Proposition 13 period. Admissions have decreased somewhat (from 12 between July and September, to 7 in the second quarter), but post-discharge placements are a growing problem now. Nine adolescents have been discharged since July, the majority because under the Roger S. decision they had the right to sign themselves out and permanent conservatorship could not be supported. All youngsters discharged have needed continued residential placement or partial hospitalization services which are extremely limited in Alameda County. Administrative staff in Mental Health are continuing to document the needs for this population, to explore funding sources for development of critically needed placements, and to coordinate placement activities with Welfare, Probation and Public Guardian Departments. This is seriously hampered by the limited resources due to Proposition 13.

ALTERNATE LIVING SITUATIONS:

Our halfway house programs are operating at 90% of last year's funding level and are being asked to serve more disturbed clients with fewer staff. There is frequently only one staff member available on a shift to cover 12-15 patients. The facilities serve as alternatives to hospitalization. All admissions are reviewed by staff. Proposition 13 has affected other funding sources for mental health programs. The loss of Revenue Sharing and CETA funds on February 28, 1979, will close two essential support programs for the residential treatment system - Creative Living Center and the Cooperative Housing for Graduates.

PARTIAL DAY PROGRAMS

The few children's partial day programs that are operating continue to operate with NIMH, Revenue Sharing, and Short-Doyle monies. We need more of these services to meet the growing demand throughout the County.

Revenue Sharing in Alameda County will be reduced by $8 million in 1979-80. This will potentially hurt children's programs most severely as Revenue Sharing monies have been directed to children's services.

Regarding adult day programs, it had been our plan to redirect resources to meet the needs of the chronically mentally ill by shifting from just acute day treatment to a mix of acute, intermediate and socialization day care programs. It is essential to meet our clients' needs and as a resource to

case managers. It may not be possible to effect this change without our 90-10 budget and this may affect readmissions to the State Hospital.

ADULT OUTPATIENT

All adult outpatient programs report that more acutely disturbed clients are being seen. Resources are scarce or non-existen in terms of other agency supports post-Proposition 13.

We are asking staff to increase workload and prepare for new case recording guidelines and other quality assurance standards when morale is at an all-time low. Recruitment is difficult because of anxiety about further cuts and seniority issues regarding order of layoff. Pay scales are not as attractive as possible.

CHILDREN'S OUTPATIENT SERVICES

Vacant positions created by Proposition 13 layoffs and subsequent resignations at Children's Services are in the process of being filled. Direct services and CE & I activities are increasing slowly, but referrals are lower than usual for the time of year. This may be a reflection of Proposition 13 effects on other referring systems, such as schools, Welfare, Probation, etc.

The Guidance Clinic and Dependent Children's Clinic budgets were reduced to eliminate the County overmatch. Staff is now in place in Guidance Clinic and new leadership is rebuilding. The number of children detained in Juvenile Hall or in the dependency cottage in need of mental health services increases. We are working with Probation and Welfare and the Courts to develop solutions but progress is slow.

SERVICES TO MINORITIES

All County mental health programs serve minority clients. Bilingual positions were retained in many cases and services were provided; however, bumping did occur and caseloads were disrupted. Bicultural, mainly Black staff, were not protected and access to minority staff was limited at some service sites.

Our program pholosophically believes that all citizens of the community in Alameda County have the right to have access to care at a County-operated facility regardless of race, origin, age or sex. This right has been impaired significantly.

With the serious cutbacks in support programs in Alameda County, the demand for services for minority clients is increasing.

Contractual services for ethnic minority clients suffered a 10% cutback in Short-Doyle funds. Other (non-mental health) funding may have also been reduced for some programs.

The function of these ethnic minority programs to serve as "gatekeepers" under the Short-Doyle contract to do prevention and counseling is severely impaired in some cases.

REVENUE SHARING:

The County of Alameda has always spent significant sums of Revenue Sharing dollars in health and social services. In mental health, the sum approaches $1 million. The services are basically to children and minorities. It is most important that this allocation continue but large reductions in Revenue Sharing dollars are anticipated this year.

PLANNING/TRAINING/EVALUATION:

Cuts in planning, evaluation and training have greatly impaired our ability to adequately develop appropriate services and monitor the allocation of resources. Additional and ongoing required tasks such as, Short-Doyle Plan, case recording policy, quality assurance, workload standards, in-service training, are crucial to funding, efficiency and effective management and have been dramatically hampered by staff and budget reductions. At a time when efficient planning, program monitoring and staff development are crucial, severe reductions are particularly damaging.

ADMINISTRATION

With an 11% cut in administration, consolidation and position cuts have occurred. Our ability to appropriately supervise all staff and develop quality assurance standards that can be monitored is questionable. The effective administration of contract mental health services as well as government-operated services is seriously jeopardized.

RECRUITMENT AND RETENTION

Perhaps the most far reaching and damaging effect of Proposition 13 has been the ever increasing difficulty with recruitment of new staff and retention of current employees. Because of the ongoing threat of additional cuts, potential employees are understandably reluctant to work for County government. An ever increasing number of current employees are resigning to take jobs in the private sector. This obviously impacts the continuity of services and the care provided to patients.

STATEMENT RE: DEVELOPMENT OF PSYCHIATRIC HEALTH FACILITIES

An addendum to the Plan will be submitted as soon as possible to the State Department of Mental Health (SDMH) regarding the development of Psychiatric Health Facilities (PHF) as enabled in AB 1496.

At the time of the SDMH memo (DMH 78-8) entitled, "Amendment to the County Plan Instructions," dated April 2, 1979, the extensive planning process in Alameda County was nearing completion. In order to appropriately and completely comply with the intent of the legislation to provide the information requested and to elicit the necessary review and approach, a process specific to this issue will be developed and implemented. Upon completion, this report will be submitted as an amendment to the Alameda County Short-Doyle Plan, 1979-80.

NOTE: Response to this is included in the Plan Amendment submitted August 1, 1979, to the State Department of Mental Health.

SECTION VI

CERTIFICATION

COUNTY PLAN FOR MENTAL HEALTH SERVICES
PURSUANT TO THE SHORT-DOYLE ACT

Submitted by Alameda County
for Fiscal Year 1979-80

CERTIFIED DOCUMENTS

Attach certified copies of the following:

1. The Board of Supervisor's resolution or ordinance adopting and submitting the County Short-Doyle Plan.
2. Indication that the County Short-Doyle Plan has been reviewed by the Local Mental Health Advisory Board.
3. Indication that the "Drug Abuse" portion of the County Short-Doyle Plan has been reviewed by the Local Advisory Committee.
4. A description of the procedures to insure citizen and professional involvement in the County's mental health planning process at all stages of its development and indication that the Local Mental Health Advisory Board has reviewed and approved those procedures.
5. A description of the procedures employed to protect patient's rights (per Thorn case) and naming of the responsible agent to carry out that procedure.

WE CERTIFY THAT:

A. The Mental Health Program will be administered according to Division 5 of the Welfare and Institutions Code.
B. All persons employed in this Mental Health Program (directly or through contract) meet applicable requirements contained in Division 5 of the Welfare and Institutions Code and Title 9 of the California Administrative Code unless otherwise noted in this application.
C. Employment of personnel shall be made solely on the basis of merit, without regard to race, religion, color, sex, national origin, age or physical or mental handicap.
   1. Affirmative action shall be taken to ensure that applicants are employed, and that employees are treated during employment without regard to their race, religion, color, sex, national origin, age or physical or mental handicap. Such action shall include, but not be limited to the following: employment, upgrading, demotion or transfer; recruitment or recruitment advertising; layoff or termination; rates of pay or other forms of compensation; and, selection for training, including apprenticeship. There shall be posted in conspicuous places, notices available to employees and applicants for employment provided by the County Officer responsible for contracts setting forth the provisions of the Equal Opportunity clause.
   2. All solicitations or advertisements for employees placed by or on behalf of the contractor and/or the subcontractor shall state that all qualified applicants will receive

consideration for employment without regard to race, religion, color, sex, national origin, age or physical or mental handicap.

3. Each labor union or representative of workers with which the county and/or the subcontractor has a collective bargaining agreement or other contract or understanding must post a notice provided by the County Officer responsible for contracts, advertising the labor union or worker's representative of the contractor's commitments under this Equal Opportunity clause and shall post copies of the notice in conspicuous places available to employees and applicants for employment.
4. The county and any subcontractor will furnish all information and reports required by the Department of Health and will permit access to books, records and accounts for purposes of investigation to ascertain compliance with paragraphs one through three.
5. In the event of noncompliance with the discrimination clause of this contract or as otherwise provided by state and federal law, this contract may be cancelled, terminated or suspended in whole or in part and the contractor and/or the subcontractor may be declared ineligible for further state contracts in accordance with procedures authorized in the Department of Health's Affirmative Action Complaint Process.
6. All provisions of paragraphs one through six will be included in every subcontract unless exempted by rules, regulations or orders of the Director of the Department of Health so that such provisions will be binding upon each subcontractor. The contractor will take such action with respect to any subcontract as the State may direct as a means of enforcing such provisions including sanctions for noncompliance provided, however, that in the event the contractor becomes involved in, or is threatened with, litigation with a subcontractor as a result of such direction by the State, the contractor may request in writing to the State, who, in turn, may request the United Stated to enter into such litigation to protect the interests of the State and the United States.

D. Services, benefits and facilities shall be provided to patients without regard to their race, color, creed, national origin, sex, age or physical or mental handicap and no one will be refused service because of inability to pay for such services.

1. <u>Nondiscrimination in Services, Benefits and Facilities</u>
There shall be no discrimination in the provision of services because of color, race, creed, national origin, sex, age or physical or mental handicap in accordance with Title VI of the Civil Rights Act of 1964, 42 U.S.C. Section 2000d, rules and regulations promulgated pursuant thereto, or as otherwise provided by state and federal law. For the purpose of this contract, distinctions on the grounds of race, color, creed or national origin include, but are not limited to the following: denying a participant any service or benefit to a participant which is different, or is provided in a different manner or at a different time from that

provided to other participants under this contract; subjecting a participant to segregation or separate treatment in any manner related to his receipt of any service; restricting a participant in any way in the enjoyment of any advantage or privilege enjoyed by others receiving any service or benefit; treating a participant differently from others in determining whether he satisfied any admission, enrollment quota, eligibility, membership or other requirement or condition which individuals must meet in order to be provided any service or benefit; the assignment of times or places for the provision of services on the basis of the race, color, creed or national origin of the participants to be served. The county and all subcontractors will take affirmative action to ensure that intended beneficiaries are provided services without regard to race, color, creed, national origin, sex, age or physical or mental handicap.

2. Procedure for Complaint Process
All complaints alleging discrimination in the delivery of services by the county and/or the subcontractor because of race, color, national origin, creed, sex, age or physical or mental handicap may be resolved by the State through the Department of Health's Affirmative Action Complaint Process.

3. Notice of Complaint Process
The county and all subcontractors shall, subject to the approval of the Department of Health, establish procedures under which recipients of service are informed of their rights to file a complaint alleging discrimination or a violation of their civil rights with the Department of Health.

(Signature and Title)	(Signature)
Chairman of Governing Body	Local Mental Health Director
Valerie Raymond, Chairperson	Susan Mandel, Ph.D.
Alameda County Board of Supervisors	
Date	Date

PATIENT'S LEGAL RIGHTS

The Thorn case upheld the constitutionality of the Lanterman-Petris-Short Act but stated that suitable safeguards must be maintained to protect the rights of patients to counsel and to seek release on habeas corpus. The court cited the procedure of the San Diego Superior Court in the appointment of counsel after the receipt of a copy of the 14-day certification as providing adequate protection to the patient. Procedures approved by the court were:

1. That the certificated person be provided with counsel at the time he receives the written notice of certification under Section 5252.

2. That counsel or some other third party not connected with the treatment facility be present at the time the patient's right to a hearing is explained to him.

3. That a third party — the patient's attorney, the public defender, or the mental health counselor — visit the patient immediately after the notice of certification is submitted to the court and other parties as required by Section 5253.

TO BE COMPLETED BY THE COUNTY

Our county uses procedure 1, 2, 3 (select one of the above procedures, or if you use another, then attach a description). (See attached policy.)

The responsibility to carry out the above procedure in our county was given to Jack York, M.D., Chief, Department of Psychiatry.

COUNTY OF ALAMEDA)
)
STATE OF CALIFORNIA) ss.
)
)

I, _____, do hereby certify that a copy of the attached document has been delivered to the Chairman of the Alameda County Board of Supervisors pursuant to the provisions of Section 25103 of the Government Code.

ATTEST:

_____
(Title)

By: _____
(Signature)

SERVING 14-DAY CERTIFICATION

POLICY: It is the responsibility of the Head Nurse, or in her absence, the Nursing Supervisor, to serve the patient with a copy of the petition for 14-day certification and to inform the patient of his legal rights.

BACKGROUND: Lanterman-Petris-Short Act, Chapter 11, Article 3, Sections 5252.1 and 5253. Section 5252.1 "The person delivering the copy of the notice of certification to the person certified shall, at the time of delivery, inform the person certified of his legal right to a judicial review by habeas corpus, and shall explain the term to him, and shall inform the person certified of his right to counsel including court-appointed counsel pursuant to Section 5276." (Added by Stats. 1969, Ch. 722, Operative on July 1, 1976. Effective August 8, 1969.)

Section 5253 "A copy of the certification notice as set forth in Section 5252 shall be personally delivered to the person certified. A copy of such notice shall be filed with the superior court on the same day as the date of the certification or, if the court is not open for business on that day, as soon thereafter as the court is open for business. A copy shall also be sent to the person's attorney, to the district attorney, to the public defender, if any, to the facility providing intensive treatment and to the State Department of Mental Hygiene.

The person certified shall also be asked to designate any person whom he wishes informed regarding his certification. If he is incapable of making such a designation at the time of certification, he shall be asked to designate such person as soon as he is capable." (Amended by Stats. 1968, Ch. 1374, and by Stats. 1970, Ch. 1627.)

PROCEDURE:

Head Nurse of Supervisor

1. Receives 14-day certification from clerk designated by appropriate treatment facility.

2. Asks patient's therapist if patient has been notified that 14-day certification was petitioned.

3. Takes the six copies of the certification to patient and requests to speak with him/her privately.

4. Explains the 14-day certification to the patient. Be sure he/she understands implications.

5. Informs patient of his/her rights.

6. Ascertains whether patient requests a hearing and records on form.

7. Signs form indicating patient notification.

8. Gives patient a carbon copy of 14-day certification.

9. If patient does not request a hearing:

   a. Returns forms to ward clerk.

   b. Makes note on nurses' notes and progress notes indicating same.

10. If patient does request a hearing:

   a. Patient signs "Report to the Supreme Court of Request by a Patient for Release" (Form #MH-1537).

   b. Head nurse or supervisor witnesses patient signature.

   c. Returns 14-day certification forms to clerk together with Release Request form.

   d. Makes note on nurses' notes and progress notes indicating same.

11. Notifies patient's therapist of patient's decision.

Same day or next working day:

Court Clerk (Superior Court)

1. Explains the 14-day certification to the patient to insure that he/she understands implications of this process.

2. Informs patient of his/her rights.

Public Defender

1. In all cases where the patient requests a writ of habeas corpus, the Public Defender's Office is automatically notified at time of serving 14-day certification. Public Defender reviews all cases as soon as he can and always prior to hearing.

ALAMEDA COUNTY MENTAL HEALTH ADVISORY BOARD

July 3, 1979

The Honorable Board of Supervisors
Administration Building
1221 Oak Street, Fifth Floor
Oakland, CA. 94612

Dear Board Members:

Consistent with our mandate, the Alameda County Mental Health Advisory Board has reviewed and approves the process by which the Alameda County Short-Doyle Plan FY 1979-80 was developed. Significant progress was made in the involvement of consumers in this year's process as well as an improved mechanism to better link the committee reports and focus the development of the final document. This process indicates improvement over the past years and in general has effectively facilitated the production of an appropriate and useful document.

In addition to the following process approval and comments, our Board will review the Short-Doyle Plan content at the July 18, 1979, Mental Health Advisory Board meeting. Additional comments from this content review will be shared with Mental Health Services, your Board, and the State Department of Mental Health.

In order to enhance future planning processes, we have delineated and present below a number of observations and areas in need of improvement or refinement.

- Development of a mechanism to consistently brief the entire Mental Health Advisory Board on the progress, process, and content of the committee work at defined points throughout the planning cycle.

- Improved adherence to the Plan process document by each of the committees, including work timeliness.

- A clarification of responsibility and accountability for citizens, Agency staff, and Mental Health Advisory Board members participating in the development of the Plan.

- Improved monitoring of the process and the work of the committees by the Mental Health Advisory Board.

- Expanded Mental Health Advisory Board solicitation of community representation throughout the planning process.

499 FIFTH STREET ■ ROOM 405 ■ OAKLAND, CA. 94607 ■ 874-5191

- Careful selection of competent, knowledgeable and organizationally key agency staff persons assigned to work with planning committees.

- Improvement of consistent Mental Health Advisory Board members' participation throughout the planning process.

- The sometimes inconsistent and shifting membership experienced by some committees may be reflective of a general low morale in the wake of Proposition 13.

With this as the close of a three-year planning cycle, and as a final comment, our Board would like to emphasize the importance of continued close cooperation between local and state mental health organizations in determining the focus and direction of mental health planning, and allowing for expanded and informed participation by concerned citizens and consumers in the future design of our mental health system.

Respectfully,

Ruth Willetts

Ruth Willetts
Chairperson

Mental Health Advisory Board

RW:BJM:kf

Mandel

July 10, 1979

HCSA
Oth Division

THE BOARD OF SUPERVISORS OF THE COUNTY OF ALAMEDA, STATE OF CALIFORNIA

On motion of Supervisor George, Seconded by Supervisor Santana,
and approved by the following vote,
Ayes: Supervisors Bort, George, Santana and Chairman Raymond - 4
Noes: Supervisors None
Excused ~~xxxxxxxx~~ Supervisor~~s~~ Cooper - 1

THE FOLLOWING RESOLUTION WAS ADOPTED: NUMBER 1 8 3 6 1 2

SUBMIT 1979-80 SHORT-DOYLE PLAN
(MENTAL HEALTH SERVICE)

BE IT RESOLVED that the Health Care Services Agency be and it is hereby authorized and directed to submit the 1979-80 Alameda County Short-Doyle Plan for Mental Health Service to the State Department of Mental Health.

I CERTIFY THAT THE FOREGOING IS A CORRECT COPY OF A RESOLUTION ADOPTED BY THE BOARD OF SUPERVISORS ALAMEDA COUNTY, CALIFORNIA JUL 10 1979

ATTEST: JUL 10 1979
THE BOARD OF SUPERVISORS

BY:

RECEIVED
JUL 18 1979
LOCAL MENTAL HEALTH DIRECTOR